
**Department of Veterans Affairs**
**Office of Inspector General**

**Office of Healthcare Inspections**

**Report No. 12-00372-221**

# Combined Assessment Program Review of the VA Sierra Nevada Health Care System Reno, Nevada

**July 16, 2012**

**Washington, DC 20420**

## Why We Did This Review

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

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

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

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

# Glossary

| | |
|---|---|
| C&P | credentialing and privileging |
| CAP | Combined Assessment Program |
| CLC | community living center |
| CRC | colorectal cancer |
| EHR | electronic health record |
| EOC | environment of care |
| facility | VA Sierra Nevada Health Care System |
| FPPE | Focused Professional Practice Evaluation |
| FY | fiscal year |
| HF | heart failure |
| JC | Joint Commission |
| MH | mental health |
| OIG | Office of Inspector General |
| POCT | point-of-care testing |
| QM | quality management |
| SCI | spinal cord injury |
| TBI | traumatic brain injury |
| VHA | Veterans Health Administration |
| VISN | Veterans Integrated Service Network |

# Table of Contents

# Executive Summary: Combined Assessment Program Review of the VA Sierra Nevada Health Care System, Reno, NV

**Review Purpose:** The purpose was to evaluate selected activities, focusing on patient care administration and quality management, and to provide crime awareness training. We conducted the review the week of May 14, 2012.

**Review Results:** The review covered 11 activities. We made no recommendations in the following activities:

- Medication Management
- Mental Health Treatment Continuity

The facility's reported accomplishments included Joint Commission recognition and a comprehensive anticoagulation program.

**Recommendations:** We made recommendations in the following nine activities:

*Moderate Sedation*: Include all required elements in pre- and post-sedation assessment documentation. Discharge patients appropriately. Monitor and report moderate sedation outcomes.

*Colorectal Cancer Screening*: Ensure patients with positive screening tests are notified of test results and receive diagnostic testing. Require clinicians to develop follow-up plans or document that no follow-up is indicated.

*Environment of Care*: Comply with environmental safety requirements, and ensure patient nutrition products are labeled and within their expiration dates.

*Point-of-Care Testing:* Assess program requirements, and take action to ensure continuous coverage and oversight. Ensure manuals are readily available, testing reagents are not expired, and glucometers are in good condition.

*Quality Management*: Include all required elements in electronic health record reviews.

*Coordination of Care*: Schedule follow-up appointments within the timeframes requested by providers.

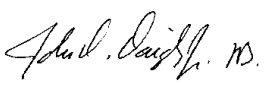
*Nurse Staffing*: Reassess unit 2C/3C's target nursing hours per patient day for weekdays.

*Polytrauma*: Ensure patients with positive traumatic brain injury screening results receive comprehensive evaluations as outlined in Veterans Health Administration policy.

*Follow-Up on Physician Credentialing and Privileging Issues*: Ensure Focused Professional Practice Evaluations for newly hired physicians comply with Veterans Health Administration policy.

## Comments

The Veterans Integrated Service Network and Facility Directors agreed with the Combined Assessment Program review findings and recommendations and provided acceptable improvement plans. We will follow up on planned actions until they are completed.



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

# Objectives and Scope

## Objectives

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

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

## Scope

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

In performing the review, we inspected selected areas, interviewed managers and employees, and reviewed clinical and administrative records. The review covered the following 11 activities:

- Coordination of Care
- CRC Screening
- EOC
- Follow-Up on Physician C&P Issues
- Medication Management
- MH Treatment Continuity
- Moderate Sedation
- Nurse Staffing
- POCT
- Polytrauma
- QM

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

The review covered facility operations for FY 2011 and FY 2012 through May 17, 2012, and was done in accordance with OIG standard operating procedures for CAP reviews. We also asked the facility to provide us with their current status on the recommendations we made in our previous CAP report (*Combined Assessment Program Review of the VA Sierra Nevada Health Care System, Reno, Nevada,* Report No. 09-03039-62, January 14, 2010). We made a repeat recommendation in physician C&P.

During this review, we presented crime awareness briefings for 170 employees. These briefings covered procedures for reporting suspected criminal activity to the OIG and included case-specific examples illustrating procurement fraud, conflicts of interest, and bribery.

Additionally, we surveyed employees regarding patient safety and quality of care at the facility. An electronic survey was made available to all facility employees, and 226 responded. We shared survey results with facility managers.

In this report, we make recommendations for improvement. Recommendations pertain to issues that are significant enough to be monitored by the OIG until corrective actions are implemented.

# Reported Accomplishments

## JC Recognition

The facility is one of 20 VA medical centers from across the Nation to earn the distinction as a top performer on key quality measures for 2010. The JC recognizes facilities that are top performers in using evidence-based care processes closely linked to positive patient outcomes. The facility was recognized for attaining and sustaining excellence in accountability measures for heart attack, HF, pneumonia, and surgical care.

## *HealthInsight*[1] Quality Award

The facility received the 2010 and 2011 *HealthInsight* Quality Award for demonstrating high quality health care and excellence in performance on publicly reported quality of care measures. The facility was rated on the quality measures for heart attack, HF, pneumonia, and surgical infection prevention.

[1] *HealthInsight* is a non-profit, community-based organization dedicated to improving health and health care in Nevada, New Mexico, and Utah.

## Spirit of Planetree[2] Award

In 2011, during its first year of affiliation with Planetree, the facility received the Spirit of Planetree Award for the Arts Program/Meaningful Activities and Entertainment category. This award recognizes the facility's efforts in facilitating healing through creativity by collaborating with the Reno arts community to offer courses in a variety of media for area veterans.

## Anticoagulation Program

The facility has implemented a comprehensive system with a robust quality assurance program that monitors time in therapeutic range, minor and major bleed rates, thromboembolic (blocking of a blood vessel by a blood clot dislodged from its site of origin) events, patients lost to follow-up, and critical test results. For high-risk areas, such as perioperative anticoagulation management, the facility created a process that includes an initial work-up note by a pharmacist containing specific recommendations. Once a plan is agreed upon, detailed patient instructions are documented in the EHR daily. To further improve patient safety, the facility has implemented electronic tools, such as decision support for deep vein thrombosis prophylaxis[3] and anticoagulation treatment and an information sharing consult system to facilitate communication from other health care providers. Additionally, the facility has implemented an anticoagulation electronic consult process for providers to obtain an expert opinion on their patients regarding complex anticoagulation issues.

[2] Planetree is a non-profit organization that provides education and information in a collaborative community of health care organizations, facilitating efforts to create patient-centered care in healing environments.
[3] Pharmacological or non-pharmacological measures used to reduce the risk of developing a blood clot in one of the major deep veins in the leg, thigh, pelvis, or abdomen that leads to impaired venous blood flow, which usually causes leg swelling and pain.

# Results
# Review Activities With Recommendations

## Moderate Sedation

The purpose of this review was to determine whether the facility had developed safe processes for the provision of moderate sedation that complied with applicable requirements.

We reviewed relevant documents, 15 EHRs, and 57 training/competency records, and we interviewed key employees. The areas marked as noncompliant in the table below needed improvement. Details regarding the findings follow the table.

| Noncompliant | Areas Reviewed |
|---|---|
| | Staff completed competency-based education/training prior to assisting with or providing moderate sedation. |
| X | Pre-sedation documentation was complete. |
| | Informed consent was completed appropriately and performed prior to administration of sedation. |
| | Timeouts were appropriately conducted. |
| X | Monitoring during and after the procedure was appropriate. |
| X | Moderate sedation patients were appropriately discharged. |
| X | The use of reversal agents in moderate sedation was monitored. |
| X | If there were unexpected events/complications from moderate sedation procedures, the numbers were reported to an organization-wide venue. |
| | If there were complications from moderate sedation, the data was analyzed and benchmarked, and actions taken to address identified problems were implemented and evaluated. |
| | The facility complied with any additional elements required by local policy. |

Pre- and Post-Sedation Assessment Documentation. VHA requires that providers document a complete history and physical examination and/or pre-sedation assessment within 30 days prior to a moderate sedation procedure.[4] VHA also requires that the patient's pain level is assessed immediately after the procedure. None of the patients' EHRs included all required elements of the history and physical examination, such as an airway assessment; history of any previous adverse experience with sedation or analgesia; and a review of tobacco, alcohol, or substance use or abuse. Additionally, three patients' EHRs did not contain evidence of pain level assessment after the procedure.

Outpatient Discharges. VHA requires that moderate sedation outpatients are discharged in the company of a responsible, designated adult.[5] When this is not possible, local policy requires that the patient be admitted to the facility overnight or that the procedure be postponed. Two patients' EHRs contained documentation indicating

[4] VHA Directive 2006-023, *Moderate Sedation by Non-Anesthesia Providers*, May 1, 2006.
[5] VHA Directive 2006-023.

that the patients had been discharged by taxi without an accompanying responsible adult.

Monitoring and Reporting of Outcomes and Reversal Agent Use. VHA requires that the outcomes of moderate sedation, including the use of reversal agents, be monitored and reported.[6] Local policy requires that complications and reversal agent use be reported quarterly to the Invasive Procedures Committee. We found that reversal agent use was not monitored. We also found that reversal agent use was not reported to the Invasive Procedures Committee for 2 of the last 4 quarters and that other sedation data and adverse events were not reported for 1 of the last 4 quarters.

## Recommendations

**1.** We recommended that processes be strengthened to ensure that pre- and post-sedation assessment documentation includes all required elements.

**2.** We recommended that processes be strengthened to ensure that all moderate sedation outpatients are either discharged in the company of a responsible, designated adult or admitted to the facility overnight or that the procedure is postponed.

**3.** We recommended that processes be strengthened to ensure that a reliable system is in place to consistently monitor and report moderate sedation outcomes, including the use of reversal agents.

[6] VHA Directive 2006-023.

## CRC Screening

The purpose of this review was to follow up on a report, *Healthcare Inspection – Colorectal Cancer Detection and Management in Veterans Health Administration Facilities* (Report No. 05-00784-76, February 2, 2006) and to assess the effectiveness of the facility's CRC screening.

We reviewed the EHRs of 25 patients who had positive CRC screening tests (10 who had screening colonoscopies and 15 who had screening fecal occult blood tests) and interviewed key employees involved in CRC management. The areas marked as noncompliant in the table below needed improvement. Details regarding the findings follow the table.

| Noncompliant | Areas Reviewed |
|---|---|
| X | Patients were notified of positive CRC screening test results within the required timeframe. |
| X | Clinicians responsible for initiating follow-up either developed plans or documented no follow-up was indicated within the required timeframe. |
| X | Patients received a diagnostic test within the required timeframe. |
| | Patients were notified of the diagnostic test results within the required timeframe. |
| | Patients who had biopsies were notified within the required timeframe. |
| | Patients were seen in surgery clinic within the required timeframe. |
| | The facility complied with any additional elements required by local policy. |

Positive CRC Screening Test Result Notification. VHA requires that patients receive notification of CRC screening test results within 14 days of the laboratory receipt date for fecal occult blood tests and that clinicians document notification.[7] The EHRs of 10 of the 15 patients who had fecal occult blood tests did not contain documented evidence of timely notification.

Follow-Up in Response to Positive CRC Screening Test. For any positive CRC screening test, VHA requires responsible clinicians to either document a follow-up plan or document that no follow-up is indicated within 14 days of the screening test.[8] The EHRs of 7 of the 15 patients who had positive fecal occult blood tests did not have a documented follow-up plan within the required timeframe.

Diagnostic Testing Timeliness. VHA requires that patients receive diagnostic testing within 60 days of positive CRC screening test results unless contraindicated.[9] Of the five patients with positive fecal occult blood tests who had diagnostic colonoscopies, two patients did not receive testing within the required timeframe.

[7] VHA Directive 2007-004, *Colorectal Cancer Screening*, January 12, 2007 (corrected copy).
[8] VHA Directive 2007-004.
[9] VHA Directive 2007-004.

## Recommendations

**4.** We recommended that processes be strengthened to ensure that patients are notified of positive CRC screening test results within the required timeframe and that clinicians document notification.

**5.** We recommended that processes be strengthened to ensure that responsible clinicians either develop follow-up plans or document that no follow-up is indicated within the required timeframe.

**6.** We recommended that processes be strengthened to ensure that patients with positive CRC screening test results receive diagnostic testing within the required timeframe.

## EOC

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

We inspected the intensive care, MH (5C), medical/surgical (2C, 3C), and the CLC inpatient units; the emergency department; and the SCI outpatient, dental, and gastroenterology endoscopy clinics. Additionally, we reviewed relevant documents and training records, and we interviewed key employees and managers. The areas marked as noncompliant in the table below needed improvement. Details regarding the findings follow the table.

| Noncompliant | Areas Reviewed for General EOC |
|---|---|
| | EOC Committee minutes reflected sufficient detail regarding identified deficiencies, progress toward resolution, and tracking of items to closure. |
| | Infection prevention risk assessment and committee minutes reflected identification of high-risk areas, analysis of surveillance activities and data, actions taken, and follow-up. |
| | Patient care areas were clean. |
| | Fire safety requirements were met. |
| X | Environmental safety requirements were met. |
| X | Infection prevention requirements were met. |
| | Medication safety and security requirements were met. |
| | Sensitive patient information was protected, and patient privacy requirements were met. |
| | The facility complied with any additional elements required by local policy. |
| | **Areas Reviewed for Dental EOC** |
| | If lasers were used in the dental clinic, staff who performed or assisted with laser procedures received medical laser safety training, and laser safety requirements were met. |
| | General infection control practice requirements in the dental clinic were met. |
| | Dental clinic infection control process requirements were met. |
| | Dental clinic safety requirements were met. |
| | The facility complied with any additional elements required by local policy. |
| | **Areas Reviewed for SCI EOC** |
| | EOC requirements specific to the SCI Center and/or outpatient clinic were met. |
| | SCI-specific training was provided to staff working in the SCI Center and/or SCI outpatient clinic. |
| | The facility complied with any additional elements required by local policy. |
| | There was a policy that addressed safe medication management, contraband detection, and inspections. |
| | MH Residential Rehabilitation Treatment Program inspections were conducted, included all required elements, and were documented. |
| | Actions were initiated when deficiencies were identified in the residential environment. |

| Noncompliant | Areas Reviewed for MH Residential Rehabilitation Treatment Program |
|---|---|
| | Access points had keyless entry and closed circuit television monitoring. |
| | Female veteran rooms and bathrooms in mixed gender units were equipped with keyless entry or door locks. |
| | The facility complied with any additional elements required by local policy. |

Environmental Safety. The JC requires the facility to identify safety risks associated with the EOC that could affect patients, staff, and others coming to the facility. In addition, VA requires that all occupied areas are separated from renovation activities by temporary smoke-tight construction partitions or other approved noncombustible or limited combustible material.[10] We found exposed computer and telephone conduits in two locations in one building. Facility managers indicated that the open ceilings with exposed conduits were not active projects. While we were onsite, the facility installed temporary enclosures.

Infection Prevention. VHA requires that all food items be clearly labeled with the expiration date and that they be routinely inspected to ensure they are within their expiration dates.[11] We found food items that were not labeled with expiration dates. In addition, we found expired patient nutritional products in several areas of the facility.

### Recommendations

**7.** We recommended that the facility conduct a comprehensive assessment of all areas undergoing renovations and take appropriate actions to ensure compliance with environmental safety requirements.

**8.** We recommended that processes be strengthened to ensure that all food items are labeled with expiration dates and that patient nutritional products are routinely inspected to ensure they are within their expiration dates.

[10] Department of Veterans Affairs, *Fire Protection Design Manual*, 6th ed., September 2011.
[11] VHA Handbook 1109.04, *Food Service Management Program*, April 11, 2007.

## POCT

The purpose of this review was to evaluate whether the facility's inpatient blood glucose POCT program complied with applicable laboratory regulatory standards and quality testing practices as required by VHA, the College of American Pathologists, and The JC.

We reviewed the EHRs of 30 patients who had glucose testing, 20 employee training and competency records, and relevant documents. We also performed physical inspections of five patient care areas where glucose POCT was performed, and we interviewed key employees involved in POCT management. The areas marked as noncompliant in the table below needed improvement. Details regarding the findings follow the table.

| Noncompliant | Areas Reviewed |
|---|---|
| X | The facility had a current policy delineating testing requirements and oversight responsibility by the Chief of Pathology and Laboratory Medicine Service. |
| X | Procedure manuals were readily available to staff. |
| | Employees received training prior to being authorized to perform glucose testing. |
| | Employees who performed glucose testing had ongoing competency assessment at the required intervals. |
| | Test results were documented in the EHR. |
| | Facility policy included follow-up actions required in response to critical test results. |
| | Critical test results were appropriately managed. |
| X | Testing reagents and supplies were current and stored according to manufacturers' recommendations. |
| | Quality control was performed according to the manufacturer's recommendations. |
| X | Routine glucometer cleaning and maintenance was performed according to the manufacturer's recommendations. |
| | The facility complied with any additional elements required by local policy. |

Program Oversight. The JC requires the Chief of Pathology and Laboratory Medicine Service to have oversight responsibility of the POCT program, which includes policy and procedures for POCT performance and supervision. While we were onsite, we learned that only the ancillary testing coordinator had access to POCT program information. There were no back-up plans nor was there an alternate assigned to ensure consistent program oversight in the absence of the program coordinator.

Procedure Manuals, Testing Reagents, and Maintenance. VHA requires that test methods and instruments have clearly written manuals available in each testing area.[12] VHA also requires that the facility follow the manufacturers' recommendations for performing the testing. This includes recommendations for quality control, reagent

[12] VHA Handbook 1106.01, *Pathology and Laboratory Medicine Service Procedures,* October 6, 2008.

storage, maintenance, and function checks. In three patient care areas, glucose POCT manuals were not readily available. Additionally, in one patient care area, we found expired testing reagents, and in two patient care areas, we found glucometers that were not in good condition.

**Recommendations**

**9.** We recommended that the Chief of Pathology and Laboratory Medicine Service assess POCT program requirements and take action to ensure continuous coverage and oversight.

**10.** We recommended that processes be strengthened to ensure that glucose POCT manuals are readily available in all testing areas, that testing reagents are current, and that glucometers are in good condition.

## QM

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

We interviewed senior managers and key QM employees, and we evaluated meeting minutes, EHRs, and other relevant documents. The area marked as noncompliant in the table below needed improvement. Details regarding the finding follow the table.

| Noncompliant | Areas Reviewed |
|---|---|
| | There was a senior-level committee/group responsible for QM/performance improvement, and it included all required members. |
| | There was evidence that inpatient evaluation data were discussed by senior managers. |
| | The protected peer review process complied with selected requirements. |
| | Licensed independent practitioners' clinical privileges from other institutions were properly verified. |
| | FPPEs for newly hired licensed independent practitioners complied with selected requirements. |
| | Staff who performed utilization management reviews met requirements and participated in daily interdisciplinary discussions. |
| | If cases were referred to a physician utilization management advisor for review, recommendations made were documented and followed. |
| | There was an integrated ethics policy, and an appropriate annual evaluation and staff survey were completed. |
| | If ethics consultations were initiated, they were completed and appropriately documented. |
| | There was a cardiopulmonary resuscitation review policy and process that complied with selected requirements. |
| | Data regarding resuscitation episodes were collected and analyzed, and actions taken to address identified problems were evaluated for effectiveness. |
| | If Medical Officers of the Day were responsible for responding to resuscitation codes during non-administrative hours, they had current Advanced Cardiac Life Support certification. |
| X | There was an EHR quality review committee, and the review process complied with selected requirements. |
| | If the evaluation/management coding compliance report contained failures/negative trends, actions taken to address identified problems were evaluated for effectiveness. |
| | Copy and paste function monitoring complied with selected requirements. |
| | The patient safety reporting mechanisms and incident analysis complied with policy. |
| | There was evidence at the senior leadership level that QM, patient safety, and systems redesign were integrated. |
| | Overall, if significant issues were identified, actions were taken and evaluated for effectiveness. |

| Noncompliant | Areas Reviewed |
|---|---|
| | Overall, there was evidence that senior managers were involved in performance improvement over the past 12 months. |
| | Overall, the facility had a comprehensive, effective QM/performance improvement program over the past 12 months. |
| | The facility complied with any additional elements required by local policy. |

EHR Review. VHA requires facilities to conduct EHR reviews that include specific elements, such as quality and accuracy.[13] Although we found evidence of monthly reviews for completeness and timeliness, we did not find evidence that other required elements were addressed.

### Recommendation

**11.** We recommended that processes be strengthened to ensure that EHR reviews include all required elements.

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

## Coordination of Care

The purpose of this review was to determine whether patients with a primary discharge diagnosis of HF received adequate discharge planning and care "hand-off" and timely primary care or cardiology follow-up after discharge that included evaluation and documentation of HF management key components.

We reviewed 28 HF patients' EHRs and relevant documents. The area marked as noncompliant in the table below needed improvement. Details regarding the finding follow the table.

| Noncompliant | Areas Reviewed |
|---|---|
| | Medications in discharge instructions matched those ordered at discharge. |
| | Discharge instructions addressed medications, diet, and the initial follow-up appointment. |
| X | Initial post-discharge follow-up appointments were scheduled within the providers' recommended timeframes. |
| | The facility complied with any additional elements required by local policy. |

Follow-Up Appointments. VHA requires that discharge instructions include recommendations regarding the initial follow-up appointment.[14] Although provider discharge instructions included specific follow-up appointment timeframes, 7 patients' appointments were not scheduled within the requested timeframes.

### Recommendation

**12.** We recommended that processes be strengthened to ensure that follow-up appointments are consistently scheduled within the timeframes requested by providers.

[14] VHA Handbook 1907.01.

## Nurse Staffing

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

We reviewed relevant documents and six training files and interviewed key employees. Additionally, we reviewed the actual nursing hours per patient day for one acute care unit (2C/3C) for 30 randomly selected days (holidays, weekdays, and weekend days) between October 2011 and March 2012. The area marked as noncompliant in the table below needed improvement. Details regarding the finding follow the table.

| Noncompliant | Areas Reviewed |
|---|---|
| | The unit-based expert panels followed the required processes. |
| | The facility expert panel followed the required processes. |
| | Members of the expert panels completed the required training. |
| | The facility completed the required steps to develop a nurse staffing methodology by the deadline. |
| X | The selected unit's actual nursing hours per patient day met or exceeded the target nursing hours per patient day. |
| | The facility complied with any additional elements required by local policy. |

Variance Between Actual Nurse Staffing and Target. VHA requires that the facility's target nursing hours per patient day be used to plan for staffing and to evaluate actual staffing.[15] Unit 2C/3C's average actual nursing hours per patient day for weekdays were significantly below the target.

### Recommendation

**13.** We recommended that unit 2C/3C's nurse manager reassess the target nursing hours per patient day for weekdays to more accurately plan for staffing and evaluate the actual staffing provided.

[15] VHA Directive 2010-034, *Staffing Methodology for VHA Nursing Personnel*, July 19, 2010.

## Polytrauma

The purpose of this review was to determine whether the facility complied with selected requirements related to screening, evaluation, and coordination of care for patients affected by polytrauma.

We reviewed relevant documents, 10 EHRs of patients with positive TBI results, and 1 training record, and we interviewed key employees. The area marked as noncompliant in the table below needed improvement. Details regarding the finding follow the table.

| Noncompliant | Areas Reviewed |
|---|---|
| | Providers communicated the results of the TBI screening to patients and referred patients for comprehensive evaluations within the required timeframe. |
| X | Providers performed timely, comprehensive evaluations of patients with positive screenings in accordance with VHA policy. |
| | Case Managers were appropriately assigned to outpatients and provided frequent, timely communication. |
| | Outpatients who needed interdisciplinary care had treatment plans developed that included all required elements. |
| | Adequate services and staffing were available for the polytrauma care program. |
| | Employees involved in polytrauma care were properly trained. |
| | Case Managers provided frequent, timely communication with hospitalized polytrauma patients. |
| | The interdisciplinary team coordinated inpatient care planning and discharge planning. |
| | Patients and their family members received follow-up care instructions at the time of discharge from the inpatient unit. |
| | Polytrauma-TBI System of Care facilities provided an appropriate care environment. |
| | The facility complied with any additional elements required by local policy. |

Comprehensive Evaluation. VHA requires that patients with positive TBI screening results at a Level IV site be offered further evaluation and treatment by clinicians with expertise in the area of TBI.[16] A higher level Polytrauma System of Care site must complete the comprehensive evaluation or a Level IV site can develop and submit an alternate plan for review by the VISN and the national Director of Physical Medicine and Rehabilitation for approval of alternate arrangements outside of the directive.

We found that all 10 patients who screened positive for TBI received the comprehensive evaluation at the facility and were not referred to a higher level Polytrauma System of Care site. Additionally, the facility did not have an alternate plan approved by the VISN and the national Director of Physical Medicine and Rehabilitation.

[16] VHA Directive 2010-012, *Screening and Evaluation of Possible Traumatic Brain Injury in Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF) Veterans*, March 8, 2010.

## Recommendation

**14.** We recommended that processes be strengthened to ensure that patients with positive TBI screening results receive a comprehensive evaluation as outlined in VHA policy.

# Review Activity With Previous CAP Recommendations

## Follow-Up on Physician C&P Issues

As a follow-up to a recommendation from our prior CAP review, we reassessed facility compliance with the privileging process.

Physician C&P. VHA requires that FPPEs are initiated for all newly hired licensed independent practitioners prior to the delivery of care and that FPPE timeframes are documented.[17] We reviewed the profiles of 13 newly hired licensed independent practitioners and identified repeat findings related to these elements. Two practitioners had no evidence that an FPPE was initiated. In addition, three profiles did not have FPPE timeframes clearly documented.

### Recommendation

**15.** We recommended that processes be strengthened to ensure that the FPPE process for newly hired licensed independent practitioners complies with VHA policy.

[17] VHA Handbook 1100.19, *Credentialing and Privileging*, November 14, 2008.

# Review Activities Without Recommendations

## Medication Management

The purpose of this review was to determine whether the facility complied with selected requirements for opioid dependence treatment, specifically, opioid agonist[18] therapy with methadone and buprenorphine and handling of methadone.

We reviewed eight EHRs of patients receiving buprenorphine for evidence of compliance with program requirements. We also reviewed relevant documents, interviewed key employees, and inspected the methadone storage area (if any). The table below details the areas reviewed. The facility generally met requirements. We made no recommendations.

| Noncompliant | Areas Reviewed |
|---|---|
| | Opioid dependence treatment was available to all patients for whom it was indicated and for whom there were no medical contraindications. |
| | If applicable, clinicians prescribed the appropriate formulation of buprenorphine. |
| | Clinicians appropriately monitored patients started on methadone or buprenorphine. |
| | Program compliance was monitored through periodic urine drug screenings. |
| | Patients participated in expected psychosocial support activities. |
| | Physicians who prescribed buprenorphine adhered to Drug Enforcement Agency requirements. |
| | Methadone was properly ordered, stored, and packaged for home use. |
| | The facility complied with any additional elements required by local policy. |

[18] A drug that has affinity for the cellular receptors of another drug and that produces a physiological effect.

## MH Treatment Continuity

The purpose of this review was to evaluate the facility's MH patients' transition from the inpatient to outpatient setting. Specifically, we evaluated compliance with selected requirements from VHA Handbook 1160.01 and VHA's performance metrics.

We interviewed key employees and reviewed relevant documents and the EHRs of 28 patients discharged from acute MH (including 10 patients deemed at high risk for suicide). The table below details the areas reviewed. The facility generally met requirements. We made no recommendations.

| Noncompliant | Areas Reviewed |
|---|---|
| | After discharge from a MH hospitalization, patients received outpatient MH follow-up in accordance with VHA policy. |
| | Follow-up MH appointments were made prior to hospital discharge. |
| | Outpatient MH services were offered at least one evening per week. |
| | Attempts to contact patients who failed to appear for scheduled MH appointments were initiated and documented. |
| | The facility complied with any additional elements required by local policy. |

# Comments

The VISN and Facility Directors agreed with the CAP review findings and recommendations and provided acceptable improvement plans. (See Appendixes C and D, pages 25–33, for the full text of the Directors' comments.) We consider Recommendation 7 closed. We will follow up on the planned actions for the open recommendations until they are completed.

| **Facility Profile[19]** | | |
|---|---|---|
| **Type of Organization** | Tertiary care medical center | |
| **Complexity Level** | Level 2 (Level 3 for intensive care unit) | |
| **VISN** | 21 | |
| **Community Based Outpatient Clinics** | Auburn, CA<br>Minden, NV<br>Fallon, NV<br>Susanville, CA<br>Winnemucca, NV (rural outreach clinic) | |
| **Veteran Population in Catchment Area** | 120,000 | |
| **Type and Number of Total Operating Beds:**<br>• **Hospital, including Psychosocial Residential Rehabilitation Treatment Program** | 124 – 38 medicine, 14 psychiatry, 12 surgery | |
| • **CLC/Nursing Home Care Unit** | 60 | |
| • **Other** | N/A | |
| **Medical School Affiliations** | University of Nevada School of Medicine<br>University of California, San Francisco | |
| • **Number of Residents** | 39 | |
| | **Current FY (through April 2012)** | **Prior FY (2011)** |
| **Resources (in millions):** | | |
| • **Total Medical Care Budget** | $227 | $218 |
| • **Medical Care Expenditures** | $113 | $217 |
| **Total Medical Care Full-Time Employee Equivalents** | 1,111 | 1,074 |
| **Workload:** | | |
| • **Number of Station Level Unique Patients** | 24,552 | 29,178 |
| • **Inpatient Days of Care:** | | |
| o **Acute Care** | 8,453 | 19,273 |
| o **CLC/Nursing Home Care Unit** | 9,737 | 21,019 |
| **Hospital Discharges** | 2,073 | 4,099 |
| **Total Average Daily Census (including all bed types)** | 99 | 110 |
| **Cumulative Occupancy Rate (in percent)** | 80 | 89 |
| **Outpatient Visits** | 186,314 | 373,102 |

[19] All data provided by facility management.

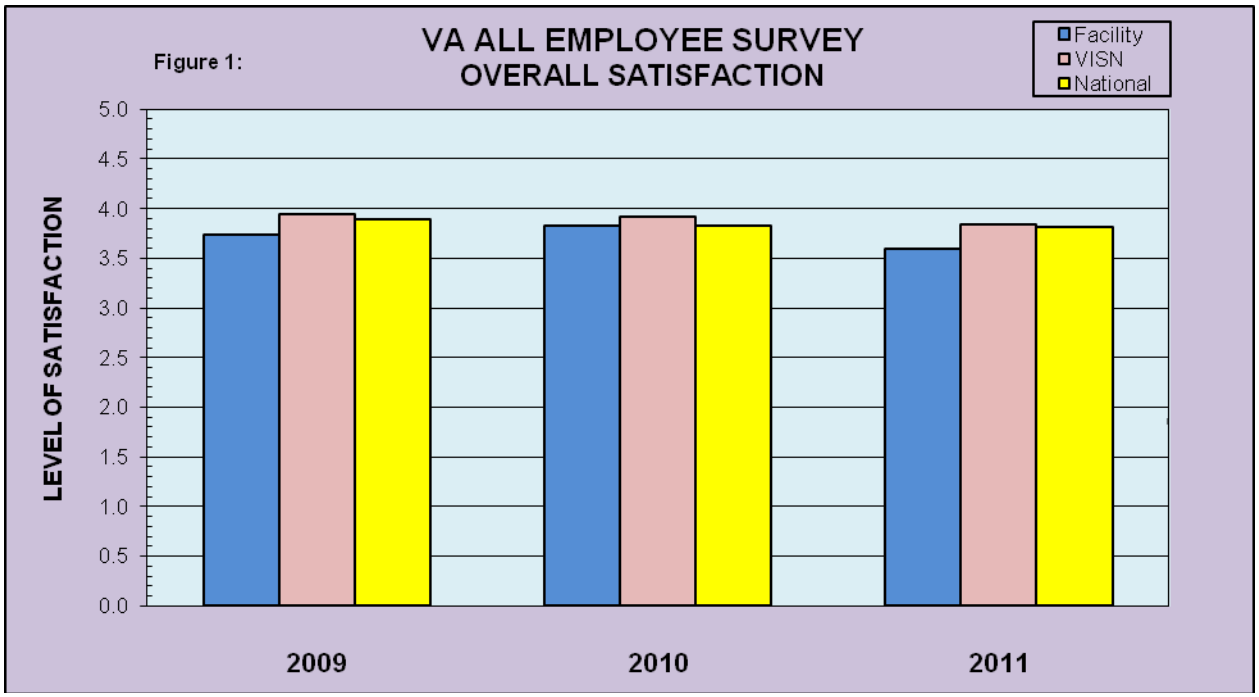
# VHA Satisfaction Surveys

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

**Table 1**

| | Inpatient Scores | | Outpatient Scores | | | |
|---|---|---|---|---|---|---|
| | FY 2011 | | FY 2011 | | | FY 2012 |
| | Inpatient Score Quarters 1–2 | Inpatient Score Quarters 3–4 | Outpatient Score Quarter 2 | Outpatient Score Quarter 3 | Outpatient Score Quarter 4 | Outpatient Score Quarter 1 |
| Facility | 71.6 | 80.7 | 62.3 | 57.0 | 63.1 | 60.9 |
| VISN | 70.5 | 70.0 | 59.4 | 58.5 | 57.4 | 58.1 |
| VHA | 63.9 | 64.1 | 55.3 | 54.2 | 54.5 | 55.0 |

Employees are surveyed annually. Figure 1 below shows the facility's overall employee scores for 2009, 2010, and 2011. Since no target scores have been designated for employee satisfaction, VISN and national scores are included for comparison.



## Hospital Outcome of Care Measures

Hospital Outcome of Care Measures show what happened after patients with certain conditions received hospital care.[20] Mortality (or death) rates focus on whether patients died within 30 days of being hospitalized. Readmission rates focus on whether patients were hospitalized again within 30 days of their discharge. These rates are based on people who are 65 and older and are "risk-adjusted" to take into account how sick patients were when they were initially admitted. Table 2 below shows facility and U.S. national Hospital Outcome of Care Measure rates for patients discharged between July 1, 2007, and June 30, 2010.[21]

**Table 2**

| | Mortality | | | Readmission | | |
|---|---|---|---|---|---|---|
| | Heart Attack | Congestive HF | Pneumonia | Heart Attack | Congestive HF | Pneumonia |
| Facility | 15.6 | 11.5 | 12.2 | 19.9 | 24.3 | 18.6 |
| U.S. National | 15.9 | 11.3 | 11.9 | 19.8 | 24.8 | 18.4 |

[20] A heart attack occurs when blood flow to a section of the heart muscle becomes blocked, and the blood supply is slowed or stopped. If the blood flow is not restored timely, the heart muscle becomes damaged. Congestive HF is a weakening of the heart's pumping power. Pneumonia is a serious lung infection that fills the lungs with mucus and causes difficulty breathing, fever, cough, and fatigue.

[21] Rates were calculated from Medicare data and do not include data on people in Medicare Advantage Plans (such as health maintenance or preferred provider organizations) or people who do not have Medicare.

# VISN Director Comments

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

**Date:** June 29, 2012

**From:** Network Director, VISN 21 (10N21)

**Subject:** **CAP Review of the VA Sierra Nevada Health Care System, Reno, NV**

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

Director, Management Review Service (VHA 10A4A4 Management Review)

1. Thank you for allowing us to review the draft OIG CAP report for VA Sierra Nevada Health Care System site visit that was conducted the week of May 14, 2012.

2. Attached is their action plan and I am confident that they will ensure the plans are implemented and monitored appropriately.

3. If you have any questions regarding the plan please contact Terry Sanders, Associate Quality Manager for VISN 21 at (707) 562-8370.

*(original signed by)*
Sheila M. Cullen

Attachment

# Facility Director Comments

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

**Date:** June 28, 2012

**From:** Director, VA Sierra Nevada Health Care System (654/00)

**Subject:** **CAP Review of the VA Sierra Nevada Health Care System, Reno, NV**

**To:** VISN 21 Director

1. Enclosed are the responses to the recommendations in the draft Office of Inspector General's report of the Combined Assessment Program review of the VA Sierra Nevada Health Care System.

2. If you have any questions regarding the responses to the recommendations in the report, please contact me at (775) 328-1263.

*(original signed by:)*
Kurt W. Schlegelmilch, M.D., FACHE

Attachment

# Comments to OIG's Report

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

**OIG Recommendations**

**Recommendation 1.** We recommended that processes be strengthened to ensure that pre- and post-sedation assessment documentation includes all required elements.

**Concur**

**Target date for completion:** July 30, 2012

Standardized pre- and post-sedation assessment templates, containing all required elements of the history and physical examination and post-procedure pain level assessment have been developed and approved by all services through the facilitation of the Moderate Sedation Task Force. The Service Chief or designee of each service providing moderate sedation is responsible for the education of all providers, including physicians, nurses and support staff. Every service providing moderate sedation will be required to utilize the standardized assessment templates.

The implementation and usage of the form will be audited by the Service Chief or designee and reported to Invasive Procedure Committee on a monthly basis. Data and findings will be tracked, trended, and presented to the Medical Executive Council quarterly.

**Recommendation 2.** We recommended that processes be strengthened to ensure that all moderate sedation outpatients are either discharged in the company of a responsible, designated adult or admitted to the facility overnight or that the procedure is postponed.

**Concur**

**Target date for completion:** July 30, 2012

Modification to the moderate sedation pre-procedure template to state "patient must have a responsible adult to transport the patient home after moderate sedation or the provider must admit the patient to observation" has been accomplished. Education of VHA Directive 2006-023 and VA Sierra Nevada Health Care System Directive 112-14 for moderate sedation on outpatient discharges will be provided through the facilitation of the Moderate Sedation Task Force. The Service Chief or designee of each service providing moderate sedation is responsible for the re-education of all providers, including physicians, nurses and support staff, to ensure that all moderate sedation patients are either discharged in the company of a responsible, designated adult, admitted to the facility overnight or the procedure is postponed.

If a patient presents to the Emergency Department and has an urgent or emergent need for the procedure but does not have a ride, the patient will be admitted. The patient will be admitted to the medical/surgical floor for observation during the day tour and admitted to Emergency Department observation for the off tour hours.

The implementation and compliance with this requirement will be audited by the Service Chief or designee. Data and findings will be tracked, trended, and presented to the Invasive Procedures Committee on a monthly basis and presented to the Medical Executive Council quarterly.

**Recommendation 3.** We recommended that processes be strengthened to ensure that a reliable system is in place to consistently monitor and report moderate sedation outcomes, including the use of reversal agents.

**Concur**

**Target date for completion:** August 1, 2012

The local Directive Sedation and Analgesia 112-14 is being updated to be consistent with the VHA directive on moderate sedation, including the monitor and report of moderate sedation outcomes.

A standardized adverse events form has been created and approved to include all adverse events, including the use of reversal agent. The Service Chief or designee of each service providing moderate sedation is responsible for the education of all providers, including physicians, nurses and support staff, needing to utilize the standardized moderate sedation outcome form.

The implementation and usage of the form will be audited by the Service Chief or designee and results of the monitoring will be reported to Invasive Procedure Committee on a monthly basis. Data and findings will be tracked, trended, and presented to the Medical Executive Council quarterly.

**Recommendation 4.** We recommended that processes be strengthened to ensure that patients are notified of positive CRC screening test results within the required timeframe and that clinicians document notification.

**Concur**

**Target date for completion:** July 30, 2012

All Ambulatory Care providers will receive education on VA policy timeframes for notification of CRC screenings as well as the need for documentation of the patient notification through use of the Notification of Test Results template in CPRS or telephone note documentation.

The ACOS Ambulatory Care and Section Managers in Primary Care and Community Based Outpatient Clinics will be responsible for ensuring education is completed.

The compliance with the notification of test results and proper documentation will be audited by the ACOS Ambulatory Care or designee monthly, and reported to Quality Executive Council monthly.

**Recommendation 5.** We recommended that processes be strengthened to ensure that responsible clinicians either develop follow-up plans or document that no follow-up is indicated within the required timeframe.

**Concur**

**Target date for completion:** July 30, 2012

All Ambulatory Care providers will receive education on VA policy timeframes for notification of CRC screenings as well as the need to develop follow-up plans or document that no follow-up is indicated within the required timeframe. This will be documented in CPRS Ambulatory Care Notification of Test Results template.

The ACOS Ambulatory Care and Section Managers in Primary Care and Community Based Outpatient Clinics will be responsible for ensuring education is completed.

The compliance with the follow-up plans or documentation that no follow-up is indicated will be audited by the ACOS Ambulatory Care or designee monthly, and reported to Quality Executive Council monthly.

**Recommendation 6.** We recommended that processes be strengthened to ensure that patients with positive CRC screening test results receive diagnostic testing within the required timeframe.

**Concur**

**Target date for completion:** July 15, 2012

The Nurse Practitioner for GI or designee will be responsible for maintaining the nationally approved CRC log sheet which will track all patients with a positive screen requiring a diagnostic follow up. CRC tracking tool contains the following elements: patient's name; screening modality; screening date; screening result; patient notification of result; follow up diagnostic testing recommended; follow up diagnostic testing received; follow up date of diagnostic procedure; follow up diagnostic procedure result; patient notification of follow up procedure result; and medical reason for exclusion if applicable.

The Tracking CRC log will be audited and monitored by the Medical Service Administrative Nurse on a monthly basis. Data and findings will be presented to the Quality Executive Council monthly.

**Recommendation 7.** We recommended that the facility conduct a comprehensive assessment of all areas undergoing renovations and take appropriate actions to ensure compliance with environmental safety requirements.

**Concur**

**Target date for completion:** Completed.

A written Interim Life Safety Measure (ILSM) policy is in place that covers situations when Life Safety Code deficiencies cannot be immediately corrected or during periods of construction and renovation. Additionally, members of our Construction Safety team conduct weekly inspections of all active renovation and construction projects/sites. The current process for reporting to the Environment of Care Council (EOCC) and to the Quality Executive Council (QEC) on a quarterly basis will be enforced. All areas currently are compliant.

**Recommendation 8.** We recommended that processes be strengthened to ensure that all food items are labeled with expiration dates and that patient nutritional products are routinely inspected to ensure they are within their expiration dates.

**Concur**

**Target date for completion:** July 30, 2012

All Nutrition and Food Service employees have been re-educated and receive training during new employee orientation and annually on the correct protocols for labeling, dating, and rotating food and supplements. Food service employees will check expiration dates daily on food items and nutritional supplements that they stock on the patient units. When Nutrition and Food Service employees find food items that have been placed in patient refrigerators by unit staff, patients, or family members that are not labeled or dated, they will discard the item and bring the problem to the attention of the unit Charge Nurse.

Patient Care Service (PCS) staff will review the PCS Policy-10 “Handling of Food and Beverages for Patients on Inpatient Units,” make any modification necessary, and educate employees. When notified of problems by Nutrition and Food Service employees, the Charge Nurse will bring the issue to the staff’s attention.

Nutrition and Food Services (NFS) will report any issues or findings to Quality Executive Council quarterly.

**Recommendation 9.** We recommended that the Chief of Pathology and Laboratory Medicine Service assess POCT program requirements and take action to ensure continuous coverage and oversight.

**Concur**

**Target date for completion:** July 15, 2012

The Chief of Pathology and Laboratory Medicine Service will appoint a Point of Care Testing Coordinator (POCT) back-up, and ensure that the appropriate training to fulfill the POCT functions is completed.

**Recommendation 10.** We recommended that processes be strengthened to ensure that glucose POCT manuals are readily available in all testing areas, that testing reagents are current, and that glucometers are in good condition.

**Concur**

**Target date for completion:** July 15, 2012

The Point of Care Testing policy is available on-line and a hard copy available wherever glucometers are utilized. Nurse Managers will remind staff how to locate the policy.

The individual performing glucometer checks will ensure a quality control test has been completed, with results in the acceptable range, within the previous 24 hours prior to patient testing. If quality control test results fall outside of the acceptable range, the individual will notify the Ancillary Testing Coordinator.

The Ancillary Testing Coordinator will revise the Monthly Glucometer Inspection tool to include working condition of the glucometer, the presence of a POCT manual, current dates on testing strips and control solutions. Issues are tracked and trended monthly and reported by the Ancillary Testing Coordinator to Quality Executive Council quarterly.

**Recommendation 11.** We recommended that processes be strengthened to ensure that EHR reviews include all required elements.

**Concur**

**Target date for completion:** July 30, 2012

The facility has implemented a standardized documentation review form for CPRS record review, in compliance with VHA Handbook 1907.01. A representative sample of charts from each program, inpatient and outpatient, will be reviewed on a scheduled basis.

The results will be tracked, monitored, and trended with an established goal and reported to the Data Analysis Committee (DAC) monthly and Quality Executive Council quarterly. Any outliers identified are reported to the appropriate Service Chief for immediate action.

The DAC chairperson or designee will be responsible for ensuring the completion of the audits, monthly and quarterly reporting, and tracking completion.

**Recommendation 12.** We recommended that processes be strengthened to ensure that follow-up appointments are consistently scheduled within the timeframes requested by providers.

**Concur**

**Target date for completion:** August 15, 2012

A Standard Operating Procedure (SOP) will be developed to ensure a standardized process is in place for scheduling follow-up appointments consistent with the providers requested timeframes. Staff involved in the scheduling process will be trained on the SOP.

The Chief of Ambulatory Care or designee will complete monthly chart audits of post discharge appointment scheduling to ensure compliance. The data will be tracked, trended and reported monthly to Quality Executive Council.

**Recommendation 13.** We recommended that unit 2C/3C's nurse manager reassess the target nursing hours per patient day for weekdays to more accurately plan for staffing and evaluate the actual staffing provided.

**Concur**

**Target date for completion:** October 1, 2012

A national staffing consultant was on site in May 2012, to assist with further implementation of VHA Directive "Staffing Methodology for Nursing Personnel".

The Medical-Surgical (2C/3C) Unit Expert Panel is in the process of completing a detailed unit assessment and nursing outcome analysis.

The recommendations from the Unit Expert Panel and Facility Expert Panel will be presented to Executive Leadership for approval by August 30, 2012. The Nurse Manager will utilize the approved targeted Nursing Hours Per Patient Day (NHPPD) starting October 1, 2012.

**Recommendation 14.** We recommended that processes be strengthened to ensure that patients with positive TBI screening results receive a comprehensive evaluation as outlined in VHA policy.

**Concur**

**Target date for completion:** June 27, 2012

The alternate plan was developed and approved by VISN and by VACO Physical Medicine and Rehabilitation Office. Veterans who have needs related to TBI that cannot be met will be referred to the Palo Alto, California, VA, a Level I Polytrauma facility for treatment.

**Recommendation 15.** We recommended that processes be strengthened to ensure that the FPPE process for newly hired licensed independent practitioners complies with VHA policy.

**Concur**

**Target date for completion:** July 1, 2012

All Service Chiefs of newly hired licensed independent practitioners will implement and monitor the FPPE during the first six months of practice.

The Chief of Quality Management or designee will track all newly hired independent practitioners to ensure the FPPE timeframes are followed. The Chief of Quality Management or designee will notify Service Chiefs in advance of the completion date for FPPE. Service Chiefs will present the FPPE to the Medical Executive Council (MEC) meeting immediately following the end of the six month timeframe. FPPE will be a standing agenda item for every MEC meeting.

If FPPE documents are not available timely, the Chief of Staff will take appropriate action with Service Chiefs and the FPPE will be presented at the next MEC meeting.

# OIG Contact and Staff Acknowledgments

| | |
|---|---|
| **Contact** | For more information about this report, please contact the OIG at (202) 461-4720. |
| **Contributors** | Mary Toy, RN, Project Leader<br>Kathleen Shimoda, RN, Team Leader<br>Daisy Arugay, MT<br>Paula Chapman, CTRS<br>Douglas Henao, RD<br>Simonette Reyes, RN<br>Jackelinne Melendez, MPA, Program Support Assistant<br>Paul Lore, Office of Investigations |

# Report Distribution

## VA Distribution

Office of the Secretary
Veterans Health Administration
Assistant Secretaries
General Counsel
Director, Sierra Pacific Network (10N21)
Director, VA Sierra Nevada Health Care System (654/00)

## Non-VA Distribution

House Committee on Veterans' Affairs
House Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
House Committee on Oversight and Government Reform
Senate Committee on Veterans' Affairs
Senate Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
Senate Committee on Homeland Security and Governmental Affairs
National Veterans Service Organizations
Government Accountability Office
Office of Management and Budget
U.S. Senate: Dean Heller, Harry Reid
U.S. House of Representatives: Shelley Berkley, Joe Heck

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