Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 12-00709-211

Combined Assessment Program Review of the Washington, DC, VA Medical Center Washington, DC

July 6, 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.

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Glossary

CAP	Combined Assessment Program
CLC	community living center
COC	coordination of care
CRC	colorectal cancer
EOC	environment of care
facility	Washington, DC, VA Medical Center
FY	fiscal year
HF	heart failure
OIG	Office of Inspector General
PRC	Peer Review Committee
PRRC	Psychosocial Rehabilitation and Recovery Center
QM	quality management
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

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Executive Summary: Combined Assessment Program Review of the Washington, DC, VA Medical Center, Washington, DC

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 March 5, 2012.

Review Results: The review covered 10 activities. We made no recommendations in the following activities:

- Polytrauma
- Psychosocial Rehabilitation and Recovery Centers

The facility's reported accomplishments included opening the Center of Innovation for Patient-Centered Care.

Recommendations: We made recommendations in the following eight activities:

Quality Management: Ensure that the committee that reviews and analyzes quality management data meets with the frequency required and that the Medical Executive Committee (MEC) discusses Inpatient Evaluation Center data. Notify the Peer Review Committee of completed corrective actions. Submit quarterly peer review reports to the MEC. Report professional practice evaluation results to the MEC. Develop a Code Blue Committee policy, and implement and evaluate actions. Ensure the Medical Record Committee oversees quality reviews and monitors the copy and paste functions.

Environment of Care: Complete a comprehensive inspection of the environment, and initiate and monitor corrective actions. Check the electronic patient tracking system every 24 hours, and document checks.

Colorectal Cancer Screening: Improve diagnostic testing timeliness. Notify patients of biopsy results.

Coordination of Care: Ensure medications ordered at discharge match those listed in discharge summaries and/or patient discharge instructions.

Moderate Sedation: Include all required elements in pre-sedation assessment documentation.

Medication Management: Administer tetanus vaccinations when indicated.

Follow-Up on Emergency Eyewash Stations: Train all appropriate staff on the operation, use, and inspection of the stations. Conduct and document weekly inspections, and monitor documentation.

Follow-Up on Coordination of Care Discharge Documentation: Ensure that diet orders in discharge summaries match those in discharge instructions. Address activity levels in discharge summaries and discharge instructions.

Comments

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

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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 10 activities:

- COC
- CRC Screening
- EOC
- Follow-Up on COC Discharge Documentation
- Follow-Up on Emergency Eyewash Stations
- Medication Management
- Moderate Sedation
- Polytrauma
- PRRCs
- 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 March 5, 2012, and was done in accordance with OIG standard operating procedures for CAP reviews. We also followed up on selected recommendations from our prior CAP review of the facility (*Combined Assessment Program Review of the Washington, DC, VA Medical Center, Washington, DC,* Report No. 09-02376-02, October 5, 2009). (See Appendix B for further details.) The facility had repeat findings in discharge medications, emergency eyewash stations, and COC discharge documentation.

During this review, we presented crime awareness briefings for 87 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 477 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

Center of Innovation for Patient-Centered Care

The facility was selected to be one of five VHA health care facilities with a Center of Innovation for Patient-Centered Care. The facility was selected based on its demonstrated excellence in performance and ability to produce cultures of patient-centered care within the organization. Being part of the Center of Innovation program allows the facility to expand current programs using innovative technology and facilitates sharing of best practices and collaborative learning by encouraging relationships with other Centers of Innovation within VA.

Electronic Resource Management Center

The facility designed and implemented an electronic Resource Management Center to replace numerous outdated systems with one efficient means of tracking and prioritizing requests for human, financial, and equipment resources. The center provides an electronic “one-stop” program for requests requiring fiscal and leadership approval. It has a comprehensive inventory of requests for review by the Resource Management Committee and includes a monitoring/tracking system that captures decision making regarding resource allocations. Additionally, the center has an electronic feedback mechanism to notify requesters regarding status and decision results.

The program has been established as a best practice model and is used by all three VISN 5 sites for equipment management. In addition, the program is being expanded so that VISN management will be able to use it to track high-tech, high-cost equipment.

Service Enhancements via Technology and Innovation

A facility risk assessment identified environmental constraints and limited technology as two key issues affecting the ability to enhance service delivery. Outcome measures indicated a need for a new approach to meet demand for rapid consultation during emergent situations and enhanced screening capacity during community outreach programs.

The facility implemented new technology solutions to enhance provider responsiveness to requests for rapid consultations. This technology allows for greater integration of current applications housing patient information and test results. Providers use iPADs® for mobile access to medical records, enhancing service delivery and communication. The facility is using the mVisum® technology platform, which enables cardiologists to see and review electrocardiograms and other test data from any location, such as home or another facility. This platform has increased cardiologists' ability to provide rapid consultations and communication back to providers, increasing timeliness of care.

Results

Review Activities With Recommendations

QM

The purpose of this review was to determine whether VHA facility senior managers actively supported and appropriately responded to QM efforts and whether VHA facilities complied with selected requirements within their QM programs.

We interviewed senior managers and QM personnel, and we evaluated meeting minutes, medical records, and other relevant documents. The areas marked as noncompliant in the table below needed improvement. Details regarding the findings follow the table.

Noncompliant	Areas Reviewed
X	There was a senior-level committee/group responsible for QM/performance improvement, and it included all required members.
X	There was evidence that inpatient evaluation data were discussed by senior managers.
X	The protected peer review process complied with selected requirements.
	Licensed independent practitioners' clinical privileges from other institutions were properly verified.
X	Focused Professional Practice Evaluations for newly hired licensed independent providers 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.
X	There was a cardiopulmonary resuscitation review policy and process that complied with selected requirements.
X	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 a medical record 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.
X	Copy and paste function monitoring complied with selected requirements.
	The patient safety reporting mechanisms and incident analysis complied with policy.

Noncompliant	Areas Reviewed
	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.
	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.

QM Committee. VHA requires the leadership committee that reviews and analyzes quality data to include in its membership the Director and other senior leaders.[1] The facility's designated committee did not include the required membership. The facility identified this prior to our site visit and developed a new policy establishing a Quality Council with the required membership. However, at the time of our review, the council had not yet met.

Inpatient Evaluation Data. VHA expects senior managers to discuss the data from the Inpatient Evaluation Center at a senior-level committee and to document the discussion in the meeting minutes.[2] Although records showed that the data was available to the Medical Executive Committee, there was no documentation that the data was discussed by the committee.

Peer Review. VHA requires that the PRC receive written notification upon completion of corrective actions for cases determined to be a Level 2 or 3.[3] We reviewed meeting minutes for the period December 2010–November 2011 and identified six corrective actions that should have been completed. We found no evidence that any of these completed corrective actions were reported to the committee.

VHA requires that the PRC submit quarterly reports to the Medical Executive Committee.[4] We reviewed Medical Executive Committee meeting minutes for the period December 2010–November 2011 and found that no peer review quarterly reports were submitted.

Focused Professional Practice Evaluations. VHA requires that the results from Focused Professional Practice Evaluations be reported to the Medical Executive Committee for consideration in making the recommendation on privileges for newly hired licensed independent practitioners.[5] We reviewed the profiles of 10 newly hired licensed independent practitioners and found that none of the results had been reported to the Medical Executive Committee.

[1] VHA Directive 2009-043, *Quality Management System*, September 11, 2009.
[2] Deputy of Quality Management in VHA for Operations and Management, "Evaluation of Quality Management in VHA Facilities FY2010," memorandum, February 23, 2011.
[3] VHA Directive 2010-025, *Peer Review for Quality Management*, June 3, 2010.
[4] VHA Directive 2010-025.
[5] VHA Handbook 1100.19, *Credentialing and Privileging*, November 14, 2008.

Resuscitation. VHA requires that the facility have a written policy mandating the establishment of a Cardiopulmonary Resuscitation Committee[6] to manage processes related to cardiopulmonary arrest.[7] The facility had established such a committee, but there was no local policy defining it. Additionally, through its reviews of cardiopulmonary arrests, the committee identified corrective actions; however, we did not find documentation that the actions were implemented. For example, the committee recommended providing written resuscitation algorithms for staff, but there was no documentation in subsequent meeting minutes that the action was implemented.

Medical Record Review. VHA requires facilities' Medical Record Committees to provide oversight and coordination of medical record quality reviews and to monitor the copy and paste functions.[8] We reviewed meeting minutes for the period October 2011–January 2012. We found that the Medical Record Committee did not provide oversight and coordination of medical record reviews or monitor the copy and paste functions.

Recommendations

1. We recommended that the leadership committee responsible for reviewing and analyzing QM data and initiating and tracking action items meet with the frequency required by VHA.

2. We recommended that senior managers discuss the data from the Inpatient Evaluation Center at the Medical Executive Committee and document the discussion in the committee's meeting minutes.

3. We recommended that processes be strengthened to ensure that the PRC is notified in writing when corrective actions are completed.

4. We recommended that processes be strengthened to ensure that quarterly peer review reports are submitted to the Medical Executive Committee.

5. We recommended that processes be strengthened to ensure that results from Focused Professional Practice Evaluations are reported to the Medical Executive Committee.

6. We recommended that the facility develop a Code Blue Committee policy and that processes be strengthened to ensure that actions recommended by the committee are implemented and evaluated for effectiveness.

7. We recommended that processes be strengthened to ensure that the Medical Record Committee provides oversight and coordination of medical record quality reviews and monitors the copy and paste functions.

[6] The facility's Cardiopulmonary Resuscitation Committee is the Code Blue Committee.
[7] VHA Directive 2008-063, *Oversight and Monitoring of Cardiopulmonary Resuscitative Events and Facility Cardiopulmonary Resuscitation Committees*, October 17, 2008.
[8] VHA Handbook 1907.01, *Health Information Management and Health Records*, August 25, 2006.

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 emergency department; the CLC; medical and surgical inpatient units; the locked mental health unit; the operating room; the inpatient neurology unit; the surgical intensive care unit; the inpatient polytrauma unit; and the primary care, dental, and polytrauma clinics. Additionally, we reviewed facility policies, meeting minutes, training records, and other relevant documents, and we interviewed 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 EOC
X	Patient care areas were clean and well maintained.
	Fire safety requirements were properly addressed.
X	Environmental safety requirements were met.
X	Infection prevention requirements were met.
	Medications were secured and properly stored, and medication safety practices were in place.
	Sensitive patient information was protected.
	If the CLC had a resident animal program, facility policy addressed VHA requirements.
	Laser safety requirements in the operating room were properly addressed, and users received medical laser safety training.
	The facility complied with any additional elements required by local policy.
	Areas Reviewed for Mental Health Residential Rehabilitation Treatment Program
	There was a policy that addressed safe medication management, contraband detection, and inspections.
	Mental Health 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.
	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.

Maintenance. The Joint Commission requires that areas used by patients be well maintained. During our inspection, we found damaged and missing floor and wall tiles in the corridor leading to the CLC, in patient bathrooms in the basement, and in bathrooms on the first floor. We also found missing floor tiles at the entrance of the Low Vision Clinic. Additionally, we found holes in the walls outside of the emergency department and in the CLC storeroom and the laboratory.

Patient Safety. VHA requires a basic check of electronic patient tracking systems in high-risk areas every 24 hours to ensure proper functioning and minimize risk.[9] The facility did not perform daily checks of the system in the CLC for 62 of the 92 days for which we reviewed documentation.

Infection Control. To facilitate cleaning, facility policy requires that boxes not be stored on the floor. We found cardboard boxes stored on the floor in the dental clinic and CLC storerooms and in corridors throughout the facility.

Recommendations

8. We recommended that the facility complete a comprehensive EOC inspection, initiate actions for identified deficiencies, and monitor those actions until completed.

9. We recommended that processes be strengthened to ensure that the electronic patient tracking system in the CLC is checked every 24 hours, that the daily checks are documented, and that compliance is monitored.

[9] VHA Directive 2010-052, *Management of Wandering and Missing Patients*, December 3, 2010.

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 VHA's CRC screening.

We reviewed the medical records of 20 patients who had positive CRC screening tests, and we interviewed key employees involved in CRC management. After discussion with facility staff we eliminated two patients from the review because their tests were considered diagnostic tests. The areas marked as noncompliant in the table below needed improvement. Details regarding the findings follow the table.

Noncompliant	Areas Reviewed
	Patients were notified of positive CRC screening test results within the required timeframe.
	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.
X	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.

Diagnostic Testing Timeliness. VHA requires that patients receive diagnostic testing within 60 days of positive CRC screening test results unless contraindicated.[10] Two patients failed to show for their appointments, and two patients rescheduled their tests. Of the remaining 14 patients, 4 did not receive diagnostic testing within the required timeframe. Three of these four patients received their diagnostic testing in the community through a military sharing agreement.

Biopsy Result Notification. VHA requires that patients who have a biopsy receive notification within 14 days of the date the biopsy results were confirmed and that clinicians document notification.[11] Of the 10 patients who had a biopsy, 3 records did not contain documented evidence of timely notification. Two of these three patients received their diagnostic testing in the community through a military sharing agreement.

[10] VHA Directive 2007-004, *Colorectal Cancer Screening*, January 12, 2007 (corrected copy).
[11] VHA Directive 2007-004.

Recommendations

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

11. We recommended that processes be strengthened to ensure that patients are notified of biopsy results within the required timeframe and that clinicians document notification.

COC

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 27 HF patients' medical records and relevant facility policies, and we interviewed key employees. We also followed up on a recommendation from our previous CAP review regarding discharge medication. The area marked as noncompliant in the table below needed improvement. Details regarding the finding follow the table.

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

Discharge Medications. The Joint Commission's National Patient Safety Goals require the safe use of medications and stress the importance of maintaining and communicating accurate patient medication information. In 17 records, medications ordered at discharge did not match those listed in discharge summaries and/or in patient discharge instructions. The facility had identified this problem and had developed action plans prior to our site visit. However, the plans had not been implemented. This is a repeat finding from our previous CAP review.

Recommendation

12. We recommended that processes be strengthened to ensure that medications ordered at discharge match those listed in discharge summaries and/or in patient discharge instructions.

Moderate Sedation

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

We reviewed relevant documents, 15 medical records, and 97 training/competency records, and we interviewed key individuals. The area 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.
	Monitoring during and after the procedure was appropriate.
	Moderate sedation patients were appropriately discharged.
	The use of reversal agents in moderate sedation was monitored.
	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-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 procedure where moderate sedation will be used.[12] None of the 15 patients' medical records included all required elements of the history and physical examination, such as a review of substance use or abuse.

Recommendation

13. We recommended that processes be strengthened to ensure that the pre-sedation assessment documentation includes all required elements.

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

Medication Management

The purpose of this review was to determine whether VHA facilities had properly provided selected vaccinations according to Centers for Disease Control and Prevention guidelines and VHA recommendations.

We reviewed a total of 30 medical records for evidence of screening and administration of pneumococcal vaccines to CLC residents and screening and administration of tetanus and shingles vaccines to CLC residents and primary care patients. We also reviewed documentation of selected vaccine administration requirements and interviewed key personnel.

The area marked as noncompliant in the table below needed improvement. Details regarding the finding follow the table.

Noncompliant	Areas Reviewed
	Staff screened patients for pneumococcal and tetanus vaccinations.
X	Staff properly administered pneumococcal and tetanus vaccinations.
	Staff properly documented vaccine administration.
	Vaccines were available for use.
	If applicable, staff provided vaccines as expected by the VISN.
	The facility complied with any additional elements required by local policy.

Vaccination Administration. The Centers for Disease Control and Prevention recommends that when indicated, clinicians administer pneumococcal and tetanus vaccinations. Three of the 20 records reviewed for tetanus vaccination administration lacked documentation that indicated vaccinations had been administered.

Recommendation

14. We recommended that processes be strengthened to ensure that clinicians administer tetanus vaccinations when indicated.

Review Activities With Previous CAP Recommendations

Follow-Up on Emergency Eyewash Stations

As a follow-up to a recommendation from our prior CAP review, we reassessed facility compliance with emergency eyewash training and inspection of emergency eyewash stations.

Emergency Eyewash Stations. VHA requires that plumbed emergency eyewash stations are activated weekly to flush the lines and ensure proper operation and that self-contained eyewash stations are checked weekly to ensure the flushing fluid is full and in good condition.[13] Additionally, staff assigned to work in areas where they may be exposed to corrosive materials, blood, potentially infectious materials, and specified chemicals must undergo appropriate training in the operation, use, and inspection of the eyewash stations. We inspected multiple eyewash stations and found inconsistent documentation of the required weekly activations and/or checks. Additionally, we found no evidence of the required training.

Recommendation

15. We recommended that processes be strengthened to ensure that all staff in areas where the eyewash stations are located receive training on the operation, use, and inspection of the eyewash stations; that weekly inspections and/or checks are conducted and documented; and that documentation of the inspections is monitored.

Follow-Up on COC Discharge Documentation

As a follow-up to a recommendation from our prior CAP review, we reassessed facility compliance with discharge documentation.

Discharge Documentation. VHA requires that discharge instructions and discharge summaries contain information regarding diet instructions and recommended activity levels.[14] We reviewed the medical records of 27 discharged patients. In 13 records, diets ordered in the discharge summaries did not match those in patient discharge instructions. In addition, none of the discharge summaries contained information on recommended activity levels.

Recommendation

16. We recommended that processes be strengthened to ensure that diet orders in discharge summaries match those in patient discharge instructions and that recommended activity levels are addressed in discharge summaries and in patient discharge instructions.

[13] VHA Directive 2009-026, *Location, Selection, Installation, Maintenance, and Testing of Emergency Eyewash and Shower Equipment*, May 13, 2009.
[14] VHA Handbook 1907.01.

Review Activities Without Recommendations

Polytrauma

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

We reviewed relevant documents, 10 medical records of patients with positive traumatic brain injury results, and training records, and we interviewed key staff. The table below details the areas reviewed. The facility generally met requirements. We made no recommendations.

Noncompliant	Areas Reviewed
	Providers communicated the results of the traumatic brain injury screening to patients and referred patients for comprehensive evaluations within the required timeframe.
	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-Traumatic Brain Injury System of Care facilities provided an appropriate care environment.
	The facility complied with any additional elements required by local policy.

PRRCs

The purpose of this review was to determine whether the facility had implemented a PRRC and whether VHA required programmatic and clinical elements were in place. VHA directed facilities to fully implement PRRCs by September 30, 2009, or to have a Deputy Under Secretary for Health for Operations and Management approved modification or exception. Facilities with missing PRRC programmatic or clinical elements must have an Office of Mental Health Services' approved action plan or Deputy Under Secretary for Health for Operations and Management approved modification.

We reviewed facility policies and relevant documents, inspected the PRRC, and interviewed employees. The table below details the areas reviewed. The facility generally met requirements. We made no recommendations.

Noncompliant	Areas Reviewed
	A PRRC was implemented and was considered fully designated by the Office of Mental Health Services, or the facility had an approved modification or exception.
	There was an established method for soliciting patient feedback, or the facility had an approved action plan or modification.
	The PRRC met space and therapeutic resource requirements, or the facility had an approved action plan or modification.
	PRRC staff provided required clinical services, or the facility had an approved action plan or modification.
	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 24–31, for the full text of the Directors' comments.) We will follow up on the planned actions until they are completed.

Facility Profile[15]		
Type of Organization	Tertiary care medical center	
Complexity Level	1a	
VISN	5	
Community Based Outpatient Clinics	Washington, DC Greenbelt, MD Prince George's County, MD Charlotte Hall, MD Fort Belvoir, VA	
Veteran Population in Catchment Area	383,486	
Type and Number of Total Operating Beds: • **Hospital, including Psychosocial Residential Rehabilitation Treatment Program**	Medicine Service – 93 Surgery Service – 38 Psychology Service – 28 Neurology Service - 12	
• **CLC/Nursing Home Care Unit**	120	
• **Other**	30 Compensated Work Therapy/McDermott House	
Medical School Affiliations	George Washington University Howard University Georgetown University	
• **Number of Residents**	593	
	Current FY (through March 2012)	**Prior FY (2011)**
Resources (in millions):		
• **Total Medical Care Budget**	$256.4	$442.6
• **Medical Care Expenditures**	$132.4	$403.0
Total Medical Care Full-Time Employee Equivalents	2,152.7	2,202.4
Workload:		
• **Number of Station Level Unique Patients**	41,702	75,339
• **Inpatient Days of Care:**		
o **Acute Care**	17,185	50,604
o **CLC/Nursing Home Care Unit**	13,050	38,135
Hospital Discharges	2,358	6,687
Total Average Daily Census (including all bed types)	273.2	263.1
Cumulative Occupancy Rate (in percent)	84.4	82
Outpatient Visits	235,226	702,155

[15] All data provided by facility management.

Follow-Up on Previous Recommendations		
Recommendations	**Current Status of Corrective Actions Taken**	**Repeat Recommendation? Y/N**
Emergency/Urgent Care Operations		
1. Require that all inter-facility transfer documentation complies with VHA policy.	Information for key requirements regarding transfer was added to the template in FY 2009.	N
2. Require that patients' health information is secured.	Privacy screens were added in FY 2009 and have remained in place since that time. This is monitored during daily rounding by QM and weekly at a minimum.	N
3. Require that all unused medications be secured in accordance with VHA policy.	This is monitored during daily rounding by QM and twice per week at a minimum.	N
4. Require that providers are privileged to perform procedures only after verification and documentation of required training.	Physician privileges remain verified as required for Advanced Cardiac Life Support and moderate sedation.	N
EOC		
5. Require that call buttons are installed in all patient bathrooms on the locked behavioral health unit.	Call buttons were installed in FY 2009 and remain operational.	N
6. Require that designated employees receive training in the operation and use of emergency eyewash equipment and that appropriate inspection and maintenance records are maintained.	The Safety Officer completed education in FY 2009 and provides training as needed. Areas with eyewash stations maintain inspection and maintenance logs.	Y (see page 14)
7. Require that all dirty utility room doors are locked.	All doors are locked.	N
8. Require that all EOC rounds of community based outpatient clinics are conducted and documented.	Community based outpatient clinic rounding has occurred on a biannual basis since the last CAP survey.	N

Recommendations	Current Status of Corrective Actions Taken	Repeat Recommendation? Y/N
9. Require that a ballistic window that meets VA requirements is installed at the outpatient pharmacy's dispensing counter.	The window was installed in FY 2009.	N
QM		
10. Require that all peer reviews are completed within the required timeframes.	A report has been reinstated to track the 30-day marker for initial reviews. This report is provided to the Chief of Staff and Director of QM for follow-up with service chiefs.	N
11. Require that all clinical disclosure notes contain complete documentation of the incident and the discussion that occurs with the patient or their representative and that staff appropriately identify and process institutional disclosures.	There were no institutional disclosures during FY 2010 and FY 2011. Clinical disclosures are handled per the directive.	N
12. Require that designated staff maintain current cardiopulmonary resuscitation and Advanced Cardiac Life Support certification and that local policy defines a process to monitor compliance and actions to be taken when current certification is not maintained.	Compliance is 95 percent for the facility. A new process is in place as of January 20, 2012, to boost communication of information between credentialing and privileging, nursing education, and units to the Talent Management System. Facility policy stipulates progressive corrective action will be taken for non-compliance.	N
COC		
13. Require that clinicians document in the medical record patient and/or family receipt of discharge instructions and that documentation of instructions related to medications, diet, activity level, and recommendations for follow-up care is consistent in discharge instructions and discharge summaries.	Compliant.	Y (see pages 11 and 14)

Recommendations	Current Status of Corrective Actions Taken	Repeat Recommendation? Y/N
14. Require that the requesting provider document receipt of the response to a consultation.	Mandatory consult resolution is in place.	N
Contracted/Agency Registered Nurses		
15**.** Require that nursing managers verify and document contracted/agency registered nurses primary source licensure prior to entry on duty or prior to renewal date of licensure and that mandatory training is completed and clinical competencies are demonstrated prior to the provision of patient care.	The facility stopped the use of external contract/agency nurses in FY 2009.	N
Medication Management		
16. Require that nurses consistently document pain medication effectiveness in the Bar Code Medication Administration system.	There is consistent documentation of pain medication effectiveness in the Bar Code Medication Administration system.	N

VHA Satisfaction Surveys

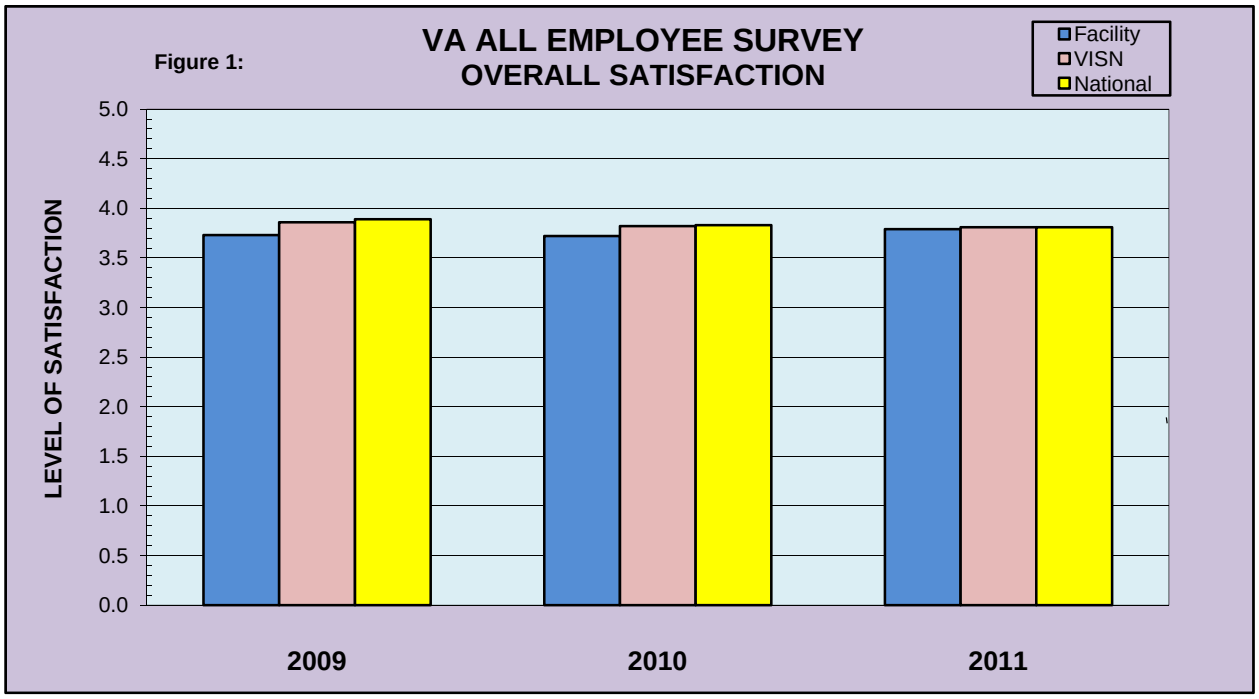
VHA has identified patient and employee satisfaction scores as significant indicators of facility performance. Patients are surveyed monthly. Table 1 below shows facility, VISN, and VHA overall inpatient and outpatient satisfaction scores and targets for FY 2011.

Table 1

	FY 2011 Inpatient Scores		FY 2011 Outpatient Scores			
	Inpatient Score Quarters 1–2	Inpatient Score Quarters 3–4	Outpatient Score Quarter 1	Outpatient Score Quarter 2	Outpatient Score Quarter 3	Outpatient Score Quarter 4
Facility	57.9	59.0	54.7	62.8	46.2	44.5
VISN	57.2	60.8	57.1	61.3	52.9	51.0
VHA	63.9	64.1	55.9	55.3	54.2	54.5

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.

Figure 1:



Hospital Outcome of Care Measures

Hospital Outcome of Care Measures show what happened after patients with certain conditions received hospital care.[16] 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.[17]

Table 2

	Mortality			Readmission		
	Heart Attack	Congestive HF	Pneumonia	Heart Attack	Congestive HF	Pneumonia
Facility	16.8	9.1	11.7	19.8	26.7	22.5
U.S. National	15.9	11.3	11.9	19.8	24.8	18.4

[16] 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.

[17] 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: May 22, 2012

From: Director, VA Capitol Health Care Network (10N5)

Subject: **CAP Review of the Washington, DC, VA Medical Center, Washington, DC**

To: Director, Washington, DC, Office of Healthcare Inspections (54DC)

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

1. VISN 5 thanks Randall Snow, JD, Project Leader for the Combined Assessment Program (CAP) Review of the Washington, DC, VA Medical Center, Lisa Barnes, MSW, Team Leader for the CAP Review of the Washington, DC, VA Medical Center, as well as the entire Office of the Inspector General (OIG) Team responsible for the review of the Washington, DC, VA Medical Center. We appreciate your diligence in evaluation, your thoughtfulness in recommendation, and your clear dedication to improving the experience of Veterans in our facility.

2. VISN 5 concurs with all 16 Recommendations put forward by the OIG Team responsible for the 2012 CAP Review of the Washington, DC, VA Medical Center.

3. Any questions regarding the provided responses can be directed to Jeffrey D. Lee, RN, MSN, Quality Management Officer of VA Capitol Health Care Network, VISN 5. Mr. Lee can be reached at 410-691-7816 or Jeffrey.Lee@va.gov.

(original signed by:)
Fernando O. Rivera, FACHE
Director, VA Capitol Health Care Network, VISN 5

Facility Director Comments

Department of Veterans Affairs **Memorandum**

Date: May 22, 2012

From: Director, Washington, DC, VA Medical Center (688/00)

Subject: **CAP Review of the Washington, DC, VA Medical Center, Washington, DC**

To: Director, VA Capitol Health Care Network (10N5)

1. The Washington DC VA Medical Center team has reviewed all of the recommendations made by the Office of the Inspector General during their recent survey conducted March 5–9, 2012. We concur with each of the findings and have worked diligently to close the 16 recommendations. We have very aggressive action plans to resolve the issues. We have interdisciplinary teams working to resolve the findings and improve the processes to ensure that the issues are addressed and can be sustained.

2. Thank you for these opportunities for improvement. The OIG team conducted the audit in a very professional, helpful manner which made the site visit productive and educational for our staff.

3. If you have any additional questions or need further information, please contact me at (202) 745-8350.

(original signed by:)
Brian A. Hawkins, MHA
Medical Center Director

Comments to OIG's Report

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

OIG Recommendations

Recommendation 1. We recommended that the leadership committee responsible for reviewing and analyzing QM data and initiating and tracking action items meet with the frequency required by VHA.

Concur

Target Completion Date: September 1, 2012 (at that time will have 3 months of data)

Quality Council has been designated as the leadership committee to review and analyze the QM data for the organization. Quality Council meets monthly. Since the survey a sharepoint to upload all committee minutes has been created and a standard method for documentation has been sent out to the organization, May 2012. Tracking of submissions and actions will be monitored by Quality Management and reported to the Quality Council monthly. A matrix for the committees and meeting schedules has been created to track compliance.

Recommendation 2. We recommended that senior managers discuss the data from the Inpatient Evaluation Center at the Medical Executive Committee and document the discussion in the committee's meeting minutes.

Concur

Target Completion Date: September 1, 2012

IPEC data has been reported to the Medical Executive Committee on a quarterly basis as it becomes available. IPEC 1QFY12 data was reported to Medical Executive Committee March 13, 2012. IPEC 2QFY12 data will be presented June 19, 2012 to MEC and June 27, 2012 to the Quality Council. MEC and Quality Council minutes will be uploaded to the sharepoint for review by QM to track compliance of this recommendation quarterly.

Recommendation 3. We recommended that processes be strengthened to ensure that the PRC is notified in writing when corrective actions are completed.

Concur

Target Completion Date: September 1, 2012

The recommendation was presented to Peer Review Committee in March, 2012 for integration into Peer Review Committee process and approved. Service Chief

Notification completed April 2012 via email. No corrective actions to date have been submitted to PRC. Required actions are tracked in the committee minutes that are submitted to QM through sharepoint for tracking of action plans, effective June 1, 2012. This process will be monitored for 3 months consecutive months to ensure continuous compliance.

Recommendation 4. We recommended that processes be strengthened to ensure that quarterly peer review reports are submitted to the Medical Executive Committee.

Concur

Target Completion Date: September 1, 2012

Peer Review Committee report to the VISN was shared with the Medical Executive Committee in March 2012. Since the OIG survey Peer Review has been added as a monthly agenda item to the MEC. Compliance will be monitored by review of the monthly MEC minutes by QM through the sharepoint and reported to Quality Council. This process will be monitored for 3 consecutive months to ensure continuous compliance.

Recommendation 5. We recommended that processes be strengthened to ensure that results from Focused Professional Practice Evaluations are reported to the Medical Executive Committee.

Concur

Target Completion Date: September 1, 2012

A tracking grid for Focused Professional Practice Evaluations (FPPE) has been developed. All new employees credentialed as licensed independent practitioners (LIP) and presented to Medical Executive Committee/Professional Standards Board (MEC/PSB) are tracked on the grid. The provider's name is listed, along with date of Medical Executive Committee approval, due date of FPPE back to the Medical Executive Committee for presentation and discussion, actual completion of FPPE and action taken/resolution. This tracking system was implemented beginning with the February 21, 2012 MEC/PSB meeting. This process will be monitored for 3 consecutive months to ensure continuous compliance.

Recommendation 6. We recommended that the facility develop a Code Blue Committee policy and that processes be strengthened to ensure that actions recommended by the committee are implemented and evaluated for effectiveness.

Concur

Target Completion Date: September 1, 2012

Since the March 2012 survey the Code Blue committee has updated the policy and presented the policy changes to the MEC May 15, 2012. The committee will meet

monthly and review data and compare to the facilities RRT data. Recommendation and analysis will be reported to the Quality Council and MEC quarterly. This process will be monitored for 3 consecutive months to ensure continuous compliance

Recommendation 7. We recommended that processes be strengthened to ensure that the Medical Record Committee provides oversight and coordination of medical record quality reviews and monitors the copy and paste functions.

Concur

Target Completion Date: September 1, 2012

Medical Records Committee has made medical record review a standing agenda item for the MRC meeting. The committee will report the committee results to Quality Council quarterly. The quality reviews and monitoring of the cutting and pasting will be conducted at the service level and submitted to HIMMS/ Medical records staff for analysis. Medical Records Committee presents results of monitoring quarterly to the Medical Executive Committee and Quality Council. This process will be monitored for 3 consecutive months to ensure continuous compliance

Recommendation 8. We recommended that the facility complete a comprehensive EOC inspection, initiate actions for the identified deficiencies, and monitor those actions until completed.

Concur

Target Completion Date: August 2, 2012

The facility conducted a comprehensive Environment of Care (EOC) review of the facility May 2012. The findings have been categorized EMS or FMS. A tracking grid to monitor completion has been developed and will be reported to EOC committee. This will be supplemental to the weekly EOC rounds and the Annual Workplace Evaluation (AWE) for which corrective actions are tracked through completion by the EOC committee. The action items from the comprehensive inspection will be reported to Quality Council over the next 3 months then quarterly.

Recommendation 9. We recommended that processes be strengthened to ensure that the electronic patient tracking system in the CLC is checked every 24 hours, that the daily checks are documented, and that compliance is monitored.

Concur

Target Completion Date: September 1, 2012

The policy has been updated to reflect manufacture recommendations and a tracking sheet provided to all nursing units. Re-education of Nurse Managers and staff along with a baseline assessment of compliance was conducted May 2012. The results were reported to NEC. Nurse Managers will monitor compliance and report to the ACN

Geriatrics Extended care weekly for 90 days effective June 1, 2012. Compliance rate will be reported to the Community Living Center (CLC) Administrative Committee monthly and Nursing Executive Committee quarterly.

Recommendation 10. 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 Completion Date: September 1, 2012

To further improve the Colorectal Cancer (CRC) screening results process we made an agreement with Washington Hospital Center to complete all procedures that cannot be scheduled in our facility. The notification of results to the patients and primary care providers is done by the GI providers for all GI procedures.

In order to address the issue of capacity we have completed renovations to the GI suite and are currently in the process of training new staff. This is expected to double the space available for procedures; it is expected to be fully operational by September 2012.

An interdisciplinary process action team will meet May, 2012 to further improve processes impacting timely scheduling of test and communication of results.

Recommendation 11. We recommended that processes be strengthened to ensure that patients are notified of biopsy results within the required timeframe and that clinicians document notification.

Concur

Target Completion Date: September 1, 2012

Chief of GI and GI staff have established a process where the colonoscopy biopsy findings are sent to the Veteran patient. A letter is also sent by the physician to notify the patient of the biopsy results. The letter is available in the electronic health record (EHR) for all clinicians to view. The established interdisciplinary Process Action Team will also develop monitoring tools to ensure compliance.

Recommendation 12. We recommended that processes be strengthened to ensure that medications ordered at discharge match those listed in discharge summaries and/or in patient discharge instructions.

Concur

Target Completion Date: June 1, 2012

The CPRS feature to auto-populate the discharge instruction template will be disabled so no information is transferred to the template. The Intern/Resident/Attending will be required to complete the discharge instruction template to include all medications the patient will be taking after discharge. The discharge summary will not be completed until the discharge instructions are complete to assure all medications have been reconciled. Monitoring for compliance will be done with the review of 25 charts per month by the Medical Records Review Committee. All clinical staff will be trained on the new process for completing the discharge instructions. This process will be included in the monthly education for the medical school trainees.

Recommendation 13. We recommended that processes be strengthened to ensure that the pre-sedation assessment documentation includes all required elements.

Concur

Required Action Complete

The social history section of the Moderate Sedation Pre-assessment template has been changed to include a detailed assessment of the use/abuse of the following substances: tobacco, cocaine, heroin and alcohol.

Recommendation 14. We recommended that processes be strengthened to ensure that clinicians administer tetanus vaccinations when indicated.

Concur

Required Action Complete

All long term care clinicians were educated on the Centers for Disease Control guidelines and adult vaccination schedules on May 1, 2012. A process was developed for Community Living Center (CLC) clinicians to screen all CLC residents at the time of admission for vaccinations that are clinically indicated. CLC clinicians and nurses document all education and vaccine administration in CLC resident charts using Preventive Medicine Screening Note template in CPRS.

Recommendation 15. We recommended that processes be strengthened to ensure that all staff in areas where the eyewash stations are located receive training on the operation, use, and inspection of the eye wash stations; that weekly inspections and/or checks are conducted and documented; and that documentation of the inspections is monitored.

Concur

Target Completion Date: June 15, 2012

The program has been developed and is being implemented. We have a training program that consists of a power point presentation, a listing of all “active” eye wash

stations and a listing of new stations that are in the process of being installed. We have a current and up to date eye wash policy.

Recommendation 16. We recommended that processes be strengthened to ensure that diet orders in discharge summaries match those in patient discharge instructions and that recommended activity levels are addressed in discharge summaries and in patient discharge instructions.

Concur

Target Completion Date: June 1, 2012

CPRS feature to auto-populate the discharge instruction template will be disabled so no information is transferred to the template. The Intern/Resident/Attending will be required to complete the discharge instruction template to include the diet and activity levels at time of discharge. The discharge summary will not be completed until the discharge instructions are complete. Monitoring for compliance will be done with the review of 25 charts per month by the Medical Records Committee. All clinical staff will be trained on the new process for completing the discharge instructions. This process will also be included in the monthly education for the medical school trainees.

OIG Contact and Staff Acknowledgments

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