Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 12-01874-245

Combined Assessment Program Review of the VA North Texas Health Care System Dallas, Texas

August 13, 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
EHR	electronic health record
EOC	environment of care
facility	VA North Texas Health Care System
FY	fiscal year
HF	heart failure
IPEC	Inpatient Evaluation Center
JC	Joint Commission
MEC	Medical Executive Committee
MH	mental health
OIG	Office of Inspector General
PI	performance improvement
POCT	point-of-care testing
PR	peer review
PRC	Peer Review Committee
PRRTP	Psychosocial Residential Rehabilitation Treatment Program
QM	quality management
RRTP	residential rehabilitation treatment program
SA	substance abuse
SCI	spinal cord injury
TBI	traumatic brain injury
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

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Executive Summary: Combined Assessment Program Review of the VA North Texas Health Care System, Dallas, TX

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 June 4, 2012.

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

- Medication Management

Recommendations: We made recommendations in the following nine activities:

Quality Management: Ensure senior-level review of Inpatient Evaluation Center data and discussion of peer review summary reports. Notify the Peer Review Committee of completed actions. Include all services in quality record reviews. Report copy and paste function monitoring results. Revise the resuscitation policy.

Environment of Care: Ensure patient care areas are clean, well maintained, and safe. Repair or replace compromised equipment. Secure medications. Require Bonham domiciliary staff to complete monthly self-inspections and to perform and document resident room and public area inspections. Ensure the Bonham domiciliary has closed circuit television monitors at entrance and egress doors.

Colorectal Cancer Screening: Notify patients of positive screening test, diagnostic testing, and biopsy results. Ensure patients receive diagnostic testing within the required timeframe. Develop follow-up plans.

Moderate Sedation: Include all elements in pre-sedation assessments. Perform timeouts immediately prior to procedures. Appropriately monitor patients during procedures.

Polytrauma: Ensure that patients with positive traumatic brain injury screening results receive comprehensive evaluations in accordance with policy and that interdisciplinary treatment plans are developed that contain all required elements.

Coordination of Care: Schedule follow-up appointments as requested.

Mental Health Treatment Continuity: Ensure discharged mental health patients on the high risk for suicide list receive follow-up at required intervals.

Point-of-Care Testing: Complete the actions required in response to critical test results.

Nurse Staffing: Complete the staffing methodology.

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.

JOHN D. DAIGH, JR., M.D.
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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
- 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 June 4, 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 North Texas Health Care System, Dallas, Texas,* Report No. 10-02983-55, January 12, 2011).

During this review, we presented crime awareness briefings for 121 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 876 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.

Results

Review Activities With Recommendations

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 areas marked as noncompliant in the table below needed improvement. Details regarding the findings follow the table.

Noncompliant	Areas Reviewed
	There was a senior-level committee/group responsible for QM/PI, and it included all required members.
X	There was evidence that inpatient evaluation data were discussed by senior managers.
X	The protected PR process complied with selected requirements.
	Licensed independent practitioners' clinical privileges from other institutions were properly verified.
	Focused Professional Practice Evaluations 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.
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 PI over the past 12 months.
	Overall, the facility had a comprehensive, effective QM/PI program over the past 12 months.
X	The facility complied with any additional elements required by local policy.

Inpatient Evaluation Data. VHA expects senior managers to discuss the data from the IPEC at a senior-level committee and to document the discussion in the meeting minutes.[1] Although we found that the data was reviewed at the Critical Care Committee, there was no evidence over the past 12 months that senior managers had discussed the data at a senior-level committee.

PR Reports. VHA requires that the MEC review a summary of the PRC's analysis quarterly.[2] Although we found brief mention of PR results in MEC meeting minutes, we only found one full quarterly summary report over the past 12 months.

PR Corrective Actions. VHA requires that the PRC receive written notification upon completion of corrective actions.[3] We reviewed meeting minutes for the period June 2011–March 2012 and identified seven corrective actions that should have been completed. There was no evidence that four of these completed corrective actions were reported to the committee.

EHR Quality Review. VHA requires facilities to perform EHR quality reviews that include a representative sample of charts from each service or program.[4] Although EHR quality reviews had been completed for acute care, long-term care, and primary care, we found no evidence of EHR quality reviews for other services or programs.

Copy and Paste Review. Local policy requires that copy and paste function monitoring results be reported quarterly to the MEC. We did not find documentation that copy and paste function monitoring results were reported to the MEC over the past 12 months.

Resuscitation. Local policy requires the Chair of the Critical Care Committee to evaluate resuscitation events. However, after discussion with nursing and respiratory therapy managers, it was clear that they also review individual resuscitation events. The policy needs to reflect the review processes currently in place.

[1] Deputy of Quality Management in VHA for Operations and Management, "Evaluation of Quality Management in VHA Facilities FY 2010," memorandum, February 23, 2011.
[2] VHA Directive 2010-025, *Peer Review for Quality Management,* June 3, 2010.
[3] VHA Directive 2010-025.
[4] VHA Handbook 1907.01, *Health Information Management and Health Records*, August 25, 2006.

Recommendations

1. We recommended that senior managers review the data from the IPEC at a senior-level committee and document the discussion in the committee's meeting minutes.

2. We recommended that PR summary reports be discussed at the MEC quarterly and that the discussion be documented in meeting minutes.

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

4. We recommended that processes be strengthened to ensure that EHR quality reviews include all services and programs.

5. We recommended that copy and paste function monitoring results be reported quarterly to the MEC.

6. We recommended that local policy be revised to reflect current resuscitation episode review processes.

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 and whether the facility's domiciliary and SA RRTPs were in compliance with selected MH RRTP requirements.

At the Dallas division, we inspected the medical, surgical, acute MH, SCI, and surgical intensive care inpatient units; the emergency department; the CLC; the dental and SCI clinics; and the SA RRTP. At the Bonham division, we inspected the CLC, the dental clinic, and the domiciliary/SA RRTP. 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.
X	Patient care areas were clean.
	Fire safety requirements were met.
X	Environmental safety requirements were met.
X	Infection prevention requirements were met.
X	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.
	Areas Reviewed for MH RRTP
	There was a policy that addressed safe medication management, contraband detection, and inspections.
X	MH RRTP inspections were conducted, included all required elements, and were documented.

Noncompliant	Areas Reviewed for MH RRTP (continued)
X	Actions were initiated when deficiencies were identified in the residential environment.
X	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.

Cleanliness, Maintenance, and Environmental Safety. The JC requires that patient care areas are clean, well maintained, and safe. In multiple patient care units, we identified floors and furnishings in need of cleaning. We also found storage and medication rooms that required cleaning. Additionally, we identified damaged furniture, holes in ceiling tiles, and improperly sealed ceiling penetrations. Further, emergency call system cords in some areas were inaccessible from floor level or were tied to or looped around handrails potentially making the system inoperable.

Infection Prevention. The JC requires the facility to take actions to minimize the possibility of transmitting infections. On two patient care units, there were surface tears on shower trolleys. In the emergency department, there were compromised surfaces on examination tables. Additionally, in two patient care area storage rooms, we identified that bottom shelves did not have protective barriers.

Medication Security. The JC requires that medications are secured from unauthorized persons. On one patient care unit, there were two unlocked medication carts in the hallway. Additionally, a unit housekeeper had the code to access the medication room.

MH RRTP Inspections. VHA requires that facilities conduct and document monthly MH RRTP self-inspections that include safety, security, and privacy and that identified deficiencies are resolved.[5] We found that Bonham domiciliary self-inspection documentation did not consistently include all required elements nor did it indicate deficiency resolution.

VHA requires facilities to conduct daily resident room inspections for unsecured medications, regular and random public area contraband inspections, and a weekly inspection of a minimum of 10 percent of resident rooms, lockers, and drawers for contraband.[6] The Bonham domiciliary did not maintain sufficient documentation to support that these inspections were completed.

MH RRTP Residential Environment. VHA requires MH RRTP environments to be maintained in compliance with VA and accrediting bodies' EOC standards for cleanliness, safety, and infection prevention.[7] In the Bonham domiciliary, we identified significant deficiencies in cleanliness of resident rooms, restrooms, and common areas.

[5] VHA Handbook 1162.02, *Mental Health Residential Rehabilitation Treatment Program (MH RRTP)*, December 22, 2010.
[6] VHA Handbook 1162.02.
[7] VHA Handbook 1162.02.

Additionally, we found that employees were not enforcing practices to minimize smoking in non-designated areas, pest activity, and infection risk.

MH RRTP General Safety. VHA requires that all MH RRTP entrance and egress doors have closed circuit television monitoring.[8] In the Bonham domiciliary, closed circuit television monitoring was not in place at all entrance and egress doors.

Recommendations

7. We recommended that processes be strengthened to ensure that patient care areas are clean, well maintained, and safe and that compliance is monitored.

8. We recommended that infection prevention processes be strengthened to ensure that patient care equipment and examination tables with compromised surfaces are repaired, removed from service, or replaced and that storage room bottom shelves have protective barriers.

9. We recommended that processes be strengthened to ensure that medications are secured at all times.

10. We recommended that processes be strengthened to ensure that monthly self-inspections in the Bonham domiciliary include all required elements, that documentation reflects when deficiencies are resolved, and that compliance is monitored.

11. We recommended that processes be strengthened to ensure that Bonham domiciliary staff perform and document required resident room and public area inspections and that compliance is monitored.

12. We recommended that managers take immediate steps to ensure the Bonham domiciliary is in compliance with EOC standards for cleanliness, safety, and infection prevention and that compliance is monitored.

13. We recommended that the Bonham domiciliary have closed circuit television monitoring at all entrance and egress doors.

[8] VHA Handbook 1162.02.

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 20 patients who had positive CRC screening 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.
X	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.

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 or the test date for sigmoidoscopy or double contrast barium enema and that clinicians document notification.[9] Four patients' EHRs 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.[10] Five patients 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.[11] Eight of the 15 patients who received diagnostic testing did not receive that testing within the required timeframe.

Diagnostic Test Result Notification. VHA requires that test results be communicated to patients no later than 14 days from the date on which the results are available to the ordering practitioner and that clinicians document notification.[12] Five of the 15 patients

[9] VHA Directive 2007-004, *Colorectal Cancer Screening*, January 12, 2007 (corrected copy).
[10] VHA Directive 2007-004.
[11] VHA Directive 2007-004.
[12] VHA Directive 2009-019, *Ordering and Reporting Test Results,* March 24, 2009.

who received diagnostic testing did not have documented evidence of timely notification in their EHRs.

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.[13] Of the 10 patients who had a biopsy, 2 EHRs did not contain documented evidence of timely notification.

Recommendations

14. 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.

15. 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.

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

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

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

[13] VHA Directive 2007-004.

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 36 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.
X	Timeouts were appropriately conducted.
X	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.[14] Twelve patients' EHRs did not include all required elements of the history and physical examination, such as a review of current medications and an airway assessment.

Timeouts. VHA requires that a timeout occur immediately prior to the start of the procedure.[15] Two patients' EHRs did not contain evidence of a timeout being performed immediately prior to the procedure.

Intra-Procedure Monitoring. VHA requires that vital signs be documented at 5-minute intervals during the procedure.[16] Seven patients' EHRs did not contain documented evidence of vital signs taken at 5-minute intervals.

[14] VHA Directive 2006-023, *Moderate Sedation by Non-Anesthesia Providers*, May 1, 2006.
[15] VHA Directive 2010-023, *Ensuring Correct Surgery and Invasive Procedures*, May 17, 2010.
[16] VHA Directive 2006-023.

Recommendations

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

20. We recommended that processes be strengthened to ensure that the EHRs of patients undergoing moderate sedation contain documentation of a timeout immediately prior to the procedure.

21. We recommended that processes be strengthened to ensure that patients are appropriately monitored during moderate sedation and that monitoring is documented in patients' EHRs.

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 EHRs of patients with positive TBI results, 10 EHRs of patients admitted to the polytrauma outpatient clinic, and 9 training 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
	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 polytrauma outpatients.
X	The interdisciplinary team coordinated outpatient care 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 be offered further evaluation and treatment by clinicians with expertise in the area of TBI.[17] All 10 of the EHRs of patients with positive TBI results contained evidence that the patients were evaluated within 30 days. However, five evaluations were completed by a physician assistant, and one evaluation was completed by a resident physician; none of these six evaluations were co-signed by an appropriate provider.

Outpatient Treatment Planning. VHA requires that polytrauma outpatients who need interdisciplinary care have a specific interdisciplinary treatment plan developed and shared with patients and/or family members.[18] None of the treatment plans were

[17] 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.
[18] VHA Handbook 1172.04, *Physical Medicine and Rehabilitation Individualized Rehabilitation and Community Reintegration Care Plan*, May 3, 2010.

interdisciplinary, and none contained all required elements, such as skills to maximize independence. In addition, four were not shared with the patient and/or family.

Recommendations

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

23. We recommended that processes be strengthened to ensure that all members of the patient's interdisciplinary team participate in the development of treatment plans that contain all required elements and that plans are shared with the patient and/or their family.

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 20 HF patients' EHRs and relevant documents, 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
	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.[19] Although provider discharge instructions requested specific follow-up appointment timeframes in 15 of the EHRs, 3 appointments were not scheduled as requested.

Recommendation

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

[19] VHA Handbook 1907.01.

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 30 patients discharged from acute MH (including 10 patients deemed at high risk for suicide). The area marked as noncompliant in the table below needed improvement. Details regarding the finding follow the table.

Noncompliant	Areas Reviewed
X	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.

Follow-Up for High Risk for Suicide Patients. Through its MH performance measures, VHA requires that patients discharged from inpatient MH who are on the high risk for suicide list receive two outpatient follow-up evaluations within 14 days of discharge and two outpatient follow-up evaluations within days 15–30 from discharge. Two of the 10 patients discharged who were on the high risk for suicide list did not receive MH follow-up at the required intervals. One patient did not receive two evaluations within 14 days of discharge, and another patient did not receive two evaluations within days 15–30 from discharge.

Recommendation

25. We recommended that processes be strengthened to ensure that all discharged MH patients who are on the high risk for suicide list receive follow-up at the required intervals and that compliance is monitored.

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, 12 employee training and competency records, and relevant documents. We also performed physical inspections of four patient care areas where glucose POCT was performed, and we interviewed key employees involved in POCT management. The area marked as noncompliant in the table below needed improvement. Details regarding the finding follow the table.

Noncompliant	Areas Reviewed
	The facility had a current policy delineating testing requirements and oversight responsibility by the Chief of Pathology and Laboratory Medicine Service.
	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.
X	Critical test results were appropriately managed.
	Testing reagents and supplies were current and stored according to manufacturers' recommendations.
	Quality control was performed according to the manufacturer's recommendations.
	Routine glucometer cleaning and maintenance was performed according to the manufacturer's recommendations.
	The facility complied with any additional elements required by local policy.

Test Results Management. When glucose values are determined to be critical, the facility requires repeat testing, provider notification, and documentation of actions taken in a note titled "Critical finger stick glucose read back." For 3 of the 10 patients who had critical test results, not all required actions were taken.

Recommendation

26. We recommended that processes be strengthened to ensure that staff complete all actions required in response to critical test results.

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 interviewed a key employee. 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.
X	The facility completed the required steps to develop a nurse staffing methodology by the deadline.
	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.

Facility Methodology Deadline. VHA required that the steps to develop the facility's staffing methodology for nursing personnel, which include convening unit-based expert panels, be completed by September 30, 2011.[20] Although the facility had not convened unit-based expert panels, an action plan is in place. The facility is actively pursuing compliance with the staffing methodology directive, and all units met with the facility expert panel by May 31, 2012.

Recommendation

27. We recommended that the facility complete the steps to develop its staffing methodology for nursing personnel.

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

Review Activity 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[21] therapy with methadone and buprenorphine and handling of methadone.

We reviewed 10 EHRs of patients receiving methadone or buprenorphine for evidence of compliance with program requirements. We also reviewed relevant documents, interviewed key employees, and inspected the methadone storage area. 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.

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

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 24–35, for the full text of the Directors' comments.) We will follow up on the planned actions until they are completed.

Facility Profile[22]		
Type of Organization	Tertiary care medical center	
Complexity Level	1a	
VISN	17	
Community Based Outpatient Clinics	Sam Rayburn Memorial Veterans Center, Bonham, TX Fort Worth Outpatient Clinic, TX Tyler, TX Denton, TX Sherman, TX Paris, TX Bridgeport, TX Granbury, TX Greenville, TX	
Veteran Population in Catchment Area	484,795 (FY 2012)	
Type and Number of Total Operating Beds: • **Hospital, including PRRTP**	Hospital – 285 Domiciliary/PRRTP – 328	
• **CLC/Nursing Home Care Unit**	240	
Medical School Affiliations	University of Texas Southwestern University of North Texas	
• **Number of Residents**	180	
	Current FY (through February 2012)	**Prior FY (2011)**
Resources (in millions):		
• **Total Medical Care Budget**	$803	$812
• **Medical Care Expenditures**	$324	$854
Total Medical Care Full-Time Employee Equivalents	4,344.3	4,336.1
Workload:		
• **Number of Station Level Unique Patients**	89,606	111,066
• **Inpatient Days of Care:**		
○ **Acute Care**	28,999	67,870
○ **CLC/Nursing Home Care Unit**	30,102	67,001
○ **Domiciliary/PRRTP**	31,771	86,224
Hospital Discharges	5,984	13,102
Total Average Daily Census (including all bed types)	598	606
Cumulative Occupancy Rate (in percent)	70.1	71
Outpatient Visits	598,663	1,411,673

[22] All data provided by facility management.

VHA Satisfaction Surveys

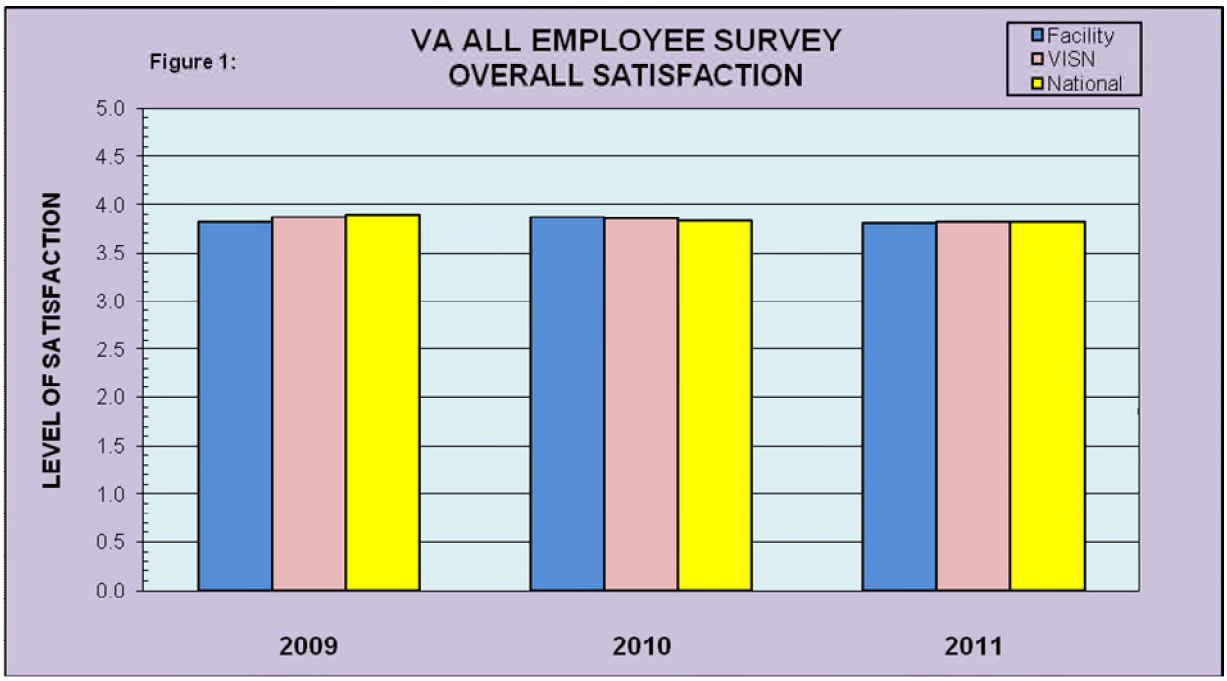
VHA has identified patient and employee satisfaction scores as significant indicators of facility performance. Patients are surveyed monthly. Table 1 below shows facility, VISN, and VHA overall inpatient satisfaction scores for FY 2011 and overall outpatient satisfaction scores for quarters 2–4 of FY 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	56.6	54.6	49.2	42.2	48.5	48.0
VISN	60.8	60.7	51.1	46.5	47.5	48.5
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.

Figure 1:



Hospital Outcome of Care Measures

Hospital Outcome of Care Measures show what happened after patients with certain conditions received hospital care.[23] 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.[24]

Table 2

	Mortality			Readmission		
	Heart Attack	Congestive HF	Pneumonia	Heart Attack	Congestive HF	Pneumonia
Facility	14.7	10.4	11.3	21.3	26.9	22.9
U.S. National	15.9	11.3	11.9	19.8	24.8	18.4

[23] 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.

[24] 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: July 24, 2012

From: Director, VA Heart of Texas Health Care Network (10N17)

Subject: **CAP Review of the VA North Texas Health Care System, Dallas, TX**

To: Director, Dallas Office of Healthcare Inspections (54DA)

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

1. Thank you for allowing me to respond to this CAP Review of the VA North Texas Health Care System, Dallas, Texas.

2. I concur with the recommendations and have ensured that action plans with target dates for completion were developed.

3. If you have further questions regarding this CAP review, please contact Judy Finley, Quality Management Officer at 817-385-3761, or Denise B. Elliott, VISN 17 HSS at 817-385-3734.

For and in the absence of
(Original signed by:)
Lawrence A. Biro
Director, VA Heart of Texas Health Care Network (10N17)

Facility Director Comments

Department of Veterans Affairs **Memorandum**

Date: July 24, 2012

From: Director, VA North Texas Health Care System (549/00)

Subject: **CAP Review of the VA North Texas Health Care System, Dallas, TX**

To: Director, VA Heart of Texas Health Care Network (10N17)

1. We appreciate the opportunity to review the draft report of the Combined Assessment Program Review completed June 4–8, 2012, for the VA North Texas Health Care System in Dallas, Texas.

2. Action plans for each finding have been identified and are in various stages of implementation. Several of the recommendations were resolved during the time of the review.

3. We would like to extend our appreciation to the entire Office of Inspector General Team who were consultative, professional and provided excellent feedback to our staff. We appreciate the thorough review and the opportunity to further improve the quality care we provide to our veterans every day.

(original signed by:)
Mr. Jeffery Milligan
Director, VA North Texas Health Care System (549/00)

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 senior managers review the data from the IPEC at a senior-level committee and document the discussion in the committee's meeting minutes.

Concur

Target date for completion: January 1, 2013

Although the IPEC data had been discussed, the minutes from ECMS (Executive Council of the Medical Staff) have not appropriately reflected the discussions. The secretary for the committee has been educated on accurately documenting the actual discussions during the committee meeting. The June 6, 2012, meeting minutes of the ECMS reflect discussion of IPEC data from the Critical Care Committee, as recommended. Review of the discussion of the quarterly report in the September and December ECMS meeting minutes will be conducted to verify compliance.

Recommendation 2. We recommended that PR summary reports be discussed at the MEC quarterly and that the discussion be documented in meeting minutes.

Concur

Target date for completion: September 1, 2012

The Peer Review Summary reports were discussed; however, the minutes from ECMS did not appropriately reflect the discussions. The secretary for the committee has been educated on accurately documenting the actual discussions during the committee meetings. The Peer Review Summary for Quarters 1 and 2, FY 2012 was reviewed and discussed at the June 6, 2012, ECMS meeting. The meeting minutes reflect discussion of the reports as recommended. Quarter 3, FY 2012 Peer Review Summary will be discussed at the August ECMS meeting. The ECMS meeting minutes will be reviewed to verify compliance.

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

Concur

Target date for completion: November 1, 2012

The Peer Review Committee will receive follow-up information regarding corrective actions based upon previous meetings decisions, starting August 15, 2012. The Peer Review Committee meeting minutes will reflect the notification and discussion of the corrective actions. The Peer Review Summary spreadsheet will be revised to track each level 2 and 3 case and responses from service chiefs once corrective actions are taken. We will monitor corrective action follow-up until 3 consecutive months demonstrate compliance.

Recommendation 4. We recommended that processes be strengthened to ensure that EHR quality reviews include all services and programs.

Concur

Target date for completion: January 1, 2013

Health Information Management (HIMS) Committee is developing an SOP detailing required elements for record reviews in ancillary programs and will include all services. The reviews will be completed by a service point of contact. The data will be submitted to HIMS Committee on a quarterly basis. Any areas below 95 percent will require an action plan from the program/service for follow-up. The follow-up will be documented in HIMS Committee minutes. We will monitor the services completing record quality reviews until 3 consecutive months demonstrate compliance.

Recommendation 5. We recommended that copy and paste function monitoring results be reported quarterly to the MEC.

Concur

Target date for completion: October 1, 2012

Copy and Paste monitoring is completed through the Medical Record Reviews Committee. The data is reported quarterly to HIMS Committee. Findings will be reported to ECMS and follow-up by each provider will be required. This follow-up is reported the next month to ensure remediation is taking place. This process will be documented in HIMS Committee minutes and reported to ECMS. We will monitor ECMS minutes for the third and fourth quarters of FY 2012 to ensure compliance is demonstrated.

Recommendation 6. We recommended that local policy be revised to reflect current resuscitation episode review processes.

Concur

Target date for completion: September 30, 2012

We are presently revising Medical Center Memorandum 118A-03 to reflect current resuscitation episode review processes.

Recommendation 7. We recommended that processes be strengthened to ensure that patient care areas are clean, well maintained, and safe and that compliance is monitored.

Concur

Target date for completion: November 1, 2012

Environmental Management Service (EMS) has implemented a revised cleanliness inspection plan. Supervisors are being trained on proper cleaning techniques, procedures, and oversight management. EMS leadership is also conducting training on cleaning with all staff. The Standard Operating Procedure (SOP) for EMS has been rewritten and will be used as a training tool. Supervisor rounding will be conducted weekly to monitor effectiveness of training. In addition, the Assistant Director will do spot checks in various patient areas. Staffing is also being increased in EMS by filling open positions. We will monitor EOC Committee meeting minutes after implementation until the rounding and inspections documentation demonstrates compliance for 3 consecutive months.

Recommendation 8. We recommended that infection prevention processes be strengthened to ensure that patient care equipment and examination tables with compromised surfaces are repaired, removed from service, or replaced and that storage room bottom shelves have protective barriers.

Concur

Target date for completion: November 1, 2012

Orders have been placed for 50 exam table top replacements, to be installed as soon as they are received. Replacement recliners for Spinal Cord Injury (SCI) Clinic and Bonham Domiciliary (DOM) will be ordered by July 31, 2012. Engineering will perform a campus-wide survey to identify torn furnishings for replacement. Updates will be reported to the Environment of Care Committee. A work order was entered, and completed, on July 10, 2012, to place a protective barrier on the bottom shelves in storage rooms that were identified as noncompliant. We will monitor EOC Committee meeting minutes after implementation until the documentation of inspections demonstrates compliance for 3 consecutive months.

Recommendation 9. We recommended that processes be strengthened to ensure that medications are secured at all times.

Concur

Target date for completion: October 1, 2012

Immediate action was taken to re-code the Medication Room on 6C. The ADPCS, Deputy ADPCS, and ACNS communicated to their staff the week of June 11, 2012, that medication rooms must always be secured and only authorized staff will have access

codes. If those who do not have access codes need admittance to the medication room, they will be monitored by a licensed nurse at all times. Monthly tracers will be initiated by nursing no later than August 1, 2012. The initial focus of this tracer will be to ensure medication carts are locked and medication room access is restricted by directly testing the carts and room doors. Tracers will be conducted in every nursing area that has medication carts and/or medication rooms and tracer results reviewed monthly until at least 3 consecutive months of data show compliance.

Recommendation 10. We recommended that processes be strengthened to ensure that monthly self-inspections in the Bonham domiciliary include all required elements, that documentation reflects when deficiencies are resolved, and that compliance is monitored.

Concur

Target date for completion: November 1, 2012

The appropriate inspection template, including items related to safety, security, and privacy, was implemented on July 9, 2012. The Lead Rehabilitation Technician will conduct one-on-one training on the revised inspection templates for all Rehabilitation Technicians by July 23, 2012. Random monthly audits of 30 inspection forms will be conducted to ensure the inspections include all required elements and deficiency resolution until 3 consecutive months demonstrate compliance. Results of the audits will be presented at the monthly Bonham Domiciliary staff meeting. In addition, the Bonham Domiciliary will continue reporting a monthly aggregate report of inspection deficiencies and tracking of deficiency resolution.

Recommendation 11. We recommended that processes be strengthened to ensure that Bonham domiciliary staff perform and document required resident room and public area inspections and that compliance is monitored.

Concur

Target date for completion: November 1, 2012

The appropriate inspection template was implemented on July 9, 2012. The Lead Rehabilitation Technician will conduct one-on-one training on the revised inspection templates for all Rehabilitation Technicians by July 23, 2012. Random monthly audits of 30 inspection forms will be conducted to ensure inspections of resident rooms and public areas are performed until 3 consecutive months demonstrate compliance. Results of the audit will be presented at the monthly Bonham Domiciliary staff meeting. In addition, the Bonham Domiciliary will continue reporting a monthly aggregate report of inspection deficiencies and tracking of deficiency resolution.

Recommendation 12. We recommended that managers take immediate steps to ensure the Bonham domiciliary is in compliance with EOC standards for cleanliness, safety, and infection prevention and that compliance is monitored.

Concur

Target date for completion: November 1, 2012

On June 7, 2012, during the weekly DOM resident meeting, it was announced that the domiciliary needed to improve the cleanliness, safety, and infection prevention practices in the DOM. DOM residents were reminded that it is their responsibility to ensure their rooms/bathrooms are clean. Residents were instructed to deep clean their rooms by 8:00 a.m. on June 8, 2012. This notification was also put in writing and left on each resident's bed. On June 8, 2012, EMS began deep cleaning the non-occupied patient rooms and common areas. All resident rooms passed inspection by July 13, 2012. Regular inspections by EMS supervisors, Bonham Domiciliary Acting Chief, and Assistant Director will be held to ensure compliance. Patients who do not pass the cleanliness inspection will be individually counseled. We will monitor EOC Committee meeting minutes after implementation until the documentation of inspections demonstrates compliance for 3 consecutive months.

Recommendation 13. We recommended that the Bonham domiciliary have closed circuit television monitoring at all entrance and egress doors.

Concur

Target date for completion: July 31, 2012

Installation of cameras has been completed. Activation of the cameras has been delayed due to IT network issues with bandwidth. The cameras will be activated and fully functioning by July 31, 2012.

Recommendation 14. 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: December 1, 2012

Ambulatory Care Service will re-educate providers during monthly staff meetings and via email regarding the requirement to notify patients within 14 days. Ambulatory Care will contact patients by phone or use the FOBT notification letter template. Ambulatory Care Service will audit 30 records per month until 90 percent compliance rate is documented for at least 3 consecutive months to ensure providers are meeting the timeliness requirement for notification and appropriate documentation.

Recommendation 15. 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: November 1, 2012

Ambulatory Care Service will remind providers during monthly staff meetings and via email regarding the process for developing and documenting follow-up plans. Patients will be notified by the provider to discuss the plan of care. If there is a need for a colonoscopy or gastroenterologist consult, the appropriate consult will be placed in a timely manner. Once the plan of care is discussed with the patient, the Primary Care Provider will complete the appropriate documentation. Ambulatory Care Service will audit 30 records per month to ensure providers are meeting the timeliness requirement for notification and appropriate documentation is met for at least 3 consecutive months.

Recommendation 16. 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: November 1, 2012

Consults to GI are placed for diagnostic testing upon receipt of positive CRC screening test results. We have hired new staff to decrease waits for diagnostic testing in Dallas and Fort Worth and resumed Saturday colonoscopies. Also, a new gastroenterologist provider is starting in July at Fort Worth GI Clinic. We will audit 30 records per month to ensure patients receive diagnostic testing within 60 days until 3 consecutive months demonstrate compliance.

Recommendation 17. We recommended that processes be strengthened to ensure that patients are notified of diagnostic test results within the required timeframe and that clinicians document notification.

Concur

Target date for completion: November 1, 2012

The noncompliant records were a result of patients being notified of biopsy results via Onc Watch, which does not transfer information to CPRS. Providers will now use CPRS to document diagnostic test results within the required timeframe. We will audit 30 records per month to ensure patients are notified of diagnostic test results within 14 days until 3 consecutive months demonstrate compliance.

Recommendation 18. 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 date for completion: November 1, 2012

The noncompliant records were a result of patients being notified of biopsy results via Onc Watch, which does not transfer information to CPRS. Providers will now use CPRS to document notification of biopsy results within 14 days. We will audit 30 records per month to ensure patients receive notification of biopsy test results in a timely manner until 3 consecutive months demonstrate compliance.

Recommendation 19. We recommended that processes be strengthened to ensure that pre-sedation assessment documentation includes all required elements.

Concur

Target date for completion: November 1, 2012

A standardized hospital-wide template is being developed. The revised template incorporates the pre-procedure note, the History & Physical, and the pre-moderate sedation note. We will audit 30 charts per month to ensure pre-sedation assessment documentation includes all required elements until 3 consecutive months demonstrate compliance.

Recommendation 20. We recommended that processes be strengthened to ensure that the EHRs of patients undergoing moderate sedation contain documentation of a timeout immediately prior to the procedure.

Concur

Target date for completion: November 1, 2012.

Due to paper records being used to document timeouts, the EHR documentation was incomplete. HIMS will now include these documents on the priority list for scanning. The facility has ordered seven high-speed scanners to help decrease turnaround time on scanning documentation. We expect to have the scanners by September 1, 2012. The Anesthesia Record Keeping System (ARKS) will be instituted to enable electronic charting of timeouts. We will audit 30 charts per month to ensure documentation of timeouts immediately prior to procedure until 3 consecutive months demonstrate compliance.

Recommendation 21. We recommended that processes be strengthened to ensure that patients are appropriately monitored during moderate sedation and that monitoring is documented in patients' EHRs.

Concur

Target date for completion: November 1, 2012

A repeat in-service with monitoring personnel regarding adequate documentation of vital signs throughout the procedure and post-procedure period has been completed. Dental Service Chief will monitor 30 charts per month to ensure staff are using the CPRS system for documentation appropriately until 3 consecutive months demonstrate compliance.

Recommendation 22. 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: September 1, 2012

An electronic request was submitted on June 14, 2012, to Computer Applications Coordinator (CAC) to modify existing TBI second level evaluations to add the requirement for co-signature of physiatrist. On June 22, 2012, the request was escalated to the national level for approval, due to concurrence needed from VACO. Until VACO concurrence, we will review 100 percent of TBI second level evaluations to ensure modifications have been made and that the physiatrist is co-signing until 3 consecutive months demonstrate compliance. An initial review, on June 25, 2012, of the 10 records shows 100 percent are compliant.

Recommendation 23. We recommended that processes be strengthened to ensure that all members of the patient's interdisciplinary team participate in the development of treatment plans that contain all required elements and that plans are shared with the patient and/or their family.

Concur

Target date for completion: October 1, 2012

Care plans are now documented on the same Plan of Care note. Initial care plans will include all interdisciplinary team goals and treatment recommendations before a care plan is provided to patient. One hundred percent of care plans will be reviewed to ensure compliance with the improvement until 3 consecutive months demonstrate compliance.

Recommendation 24. 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: October 1, 2012

Inpatient scheduling staff have received refresher training to ensure that all post discharge appointments are scheduled as required. A scheduling supervisor now reviews 100 percent of all discharges to ensure that all post discharge appointments have been scheduled. If an appointment is found to be missed, a report is sent to the MAS Chief, Inpatient Services and the scheduler for the appropriate clinic to ensure a follow-up appointment is made. Audits of CHF patient discharge appointments will be conducted on at least 30 charts per month until 3 consecutive months demonstrate compliance.

Recommendation 25. We recommended that processes be strengthened to ensure that all discharged MH patients who are on the high risk for suicide list receive follow-up at the required intervals and that compliance is monitored.

Concur

Target date for completion: October 1, 2012

Currently, Suicide Prevention Coordinators meet with each patient during admission and complete the suicide safety plan. A follow-up appointment is scheduled for the patient 7 days post discharge. RNs from the inpatient unit make wellness phone calls to the patient after 24 hours of discharge. The Suicide Prevention Coordinator will contact the patient by telephone; if they are unable to reach the patient, they will: a) contact the "Next of Kin" listed in CPRS, b) enlist help of homeless staff for patients in community shelters, c) contact local police for "Welfare Check" request, and/or d) solicit help from Mental Health Intensive Case Management Team to make home visits with patients in the community. We will review 100 percent of patients (up to 30 per month) to ensure high risk for suicide patients receive follow-up at the required intervals until 3 consecutive months demonstrate compliance.

Recommendation 26. We recommended that processes be strengthened to ensure that staff complete all actions required in response to critical test results.

Concur

Target date for completion: October 1, 2012

The ADPCS, Deputy ADPCS, and ACNS communicated to their staff the week of June 11, 2012, that Critical Lab Results policy will be followed. Noncompliance with the policy will be addressed on a case-by-case basis. Monthly chart reviews of 100 percent of critical glucometer results will be conducted by Path and Lab Testing Coordinator,

and findings will be reported to Nursing Service. Nurse Managers and Assistant Nurse Managers will monitor/track/trend to ensure greater than 90 percent compliance for 3 consecutive months.

Recommendation 27. We recommended that the facility complete the steps to develop its staffing methodology for nursing personnel.

Concur

Target date for completion: September 1, 2012

The Staffing Methodology Medical Center Memorandum is in the concurrence process. The Facility Expert Panel is finalizing Staffing Recommendations based on the Unit Based Teams' reports. The Staffing Recommendation is due to Executive Leadership June 29, 2012. Units are compiling daily staffing data and entering the data into a shared folder for review.

OIG Contact and Staff Acknowledgments

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