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

**Office of Healthcare Inspections**

**Report No. 12-03071-53**

# Combined Assessment Program Review of the Fayetteville VA Medical Center Fayetteville, North Carolina

**December 10, 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 |
| CRC | colorectal cancer |
| ED | emergency department |
| EHR | electronic health record |
| EOC | environment of care |
| facility | Fayetteville VA Medical Center |
| FPPE | Focused Professional Practice Evaluation |
| FY | fiscal year |
| HF | heart failure |
| JC | Joint Commission |
| MH | mental health |
| OIG | Office of Inspector General |
| PACT | Patient Aligned Care Team |
| POCT | point-of-care testing |
| QM | quality management |
| RRTP | residential rehabilitation treatment program |
| 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 Fayetteville VA Medical Center, Fayetteville, NC

**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 September 10, 2012.

**Review Results:** The review covered nine activities. We made no recommendations in the Nurse Staffing activity.

The facility's reported accomplishment was a system to assign patients presenting to the emergency department with non-emergent needs to a same day clinic.

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

*Environment of Care:* Ensure that Environment of Care Committee minutes reflect analysis and follow-up of inspection findings and that patient care areas are clean. Maintain a current hazardous materials inventory. Complete hazard assessments in the two identified areas. Assign and train required spinal cord injury clinic staff.

*Colorectal Cancer Screening:* Notify patients of positive screening test results within the required timeframe. Develop follow-up plans or document that no follow-up is indicated. Ensure patients with positive screening test results receive diagnostic testing within the required timeframe.

*Coordination of Care:* Ensure discharge medications match those on discharge instructions. Schedule follow-up appointments as requested. Include discharge medications in discharge summaries.

*Mental Health Treatment Continuity:* Ensure all discharged mental health patients receive follow-up at required intervals. Initiate and document attempts to follow-up with mental health patients who miss appointments.

*Polytrauma:* Ensure that the clinical service responds to consultation requests for traumatic brain injury evaluations and that all patients with positive screenings receive evaluations within the required timeframe. Comply with polytrauma training requirements.

*Quality Management:* Discuss Inpatient Evaluation Center data at a senior-level committee. Complete and report results of Focused Professional Practice Evaluations. Complete clinical service electronic health record reviews. Ensure the Electronic Health Record Committee provides oversight of quality reviews. Monitor the copy and paste functions.

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

*Moderate Sedation:* Ensure providers sign all pre-sedation assessments completed by nursing staff.

## 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.
Assistant Inspector General for
Healthcare Inspections

# Objectives and Scope

## Objectives

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

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

## Scope

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

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

- Coordination of Care
- CRC Screening
- EOC
- 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 September 7, 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 Fayetteville VA Medical Center, Fayetteville, North Carolina,* Report No. 11-02081-09, October 27, 2011).

During this review, we presented crime awareness briefings for 145 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 567 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 Accomplishment

## PACT – Same Day Clinic

The facility has experienced a significant increase in the number of veterans seeking care over the past few years. Facility leaders noted that during FY 2011, there was an increase in the number of patients seeking treatment in the ED. Some of these patients were new to the facility, and others were established patients who were already assigned to a PACT. The facility implemented a system where all new veterans who presented to the ED during administrative hours and were triaged at level 4 or 5 (low acuity requiring no or minimal resources) were sent to a PACT where they were enrolled and evaluated on the same day. Also, established patients triaged at level 4 or 5 were directed through the hand-off process to their assigned PACT teams.

In addition to easing ED congestion and appropriately routing patients to primary care teams for non-emergent care, the PACT – Same Day Clinic has provided same day enrollment and evaluation to more than 275 new veterans per month.

# Results

## Review Activities With Recommendations

### 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 ED; the primary care (Dogwood and Bravo), dermatology, infusion, dental, diabetic, and SCI clinics; the intensive care, inpatient medicine and surgery, and MH units; and the CLC (3A and 4A). 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 |
|---|---|
| X | 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. |
| | Infection prevention requirements were met. |
| | Medication safety and security requirements were met. |
| | Sensitive patient information was protected, and patient privacy requirements were met. |
| | The facility complied with any additional elements required by local policy. |
| | **Areas Reviewed for Dental EOC** |
| | If lasers were used in the dental clinic, staff who performed or assisted with laser procedures received medical laser safety training, and laser safety requirements were met. |
| | General infection control practice requirements in the dental clinic were met. |
| | Dental clinic infection control process requirements were met. |
| X | 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. |
| X | 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. |

| | Areas Reviewed for MH RRTP (continued) |
|---|---|
| | MH RRTP 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. |

Meeting Minutes. The JC requires the facility to monitor and analyze EOC issues and to take action on identified deficiencies until resolved. We reviewed monthly EOC Committee minutes and determined that they did not sufficiently reflect analysis and follow-up of findings from EOC inspections. Additionally, the minutes did not reflect that identified issues were tracked to resolution.

Cleanliness. The JC requires that areas used by patients are clean. In the ED, in the specialty clinics, and on the inpatient units, we found dirty exam rooms, restrooms, and supply rooms.

Environmental Safety. The JC requires that the facility maintain a written, current inventory of hazardous materials it uses, stores, or generates. The facility's hazardous materials inventory had not been updated since June 2011. Staff told us that the industrial hygienist position had been vacant for more than 6 months.

VHA requires that a hazard assessment be performed in all areas of the facility to determine where emergency eyewash stations are needed.[1] We found that hazard assessments had not been performed in the dental laboratory or the ED.

SCI Training. VHA requires that SCI outpatient programs have designated nurses or health technicians and that staff receive SCI-specific training.[2] We found that the facility had not assigned designated nurses or health technicians to support this program; therefore, SCI-specific training had not occurred.

## Recommendations

**1.** We recommended that processes be strengthened to ensure that EOC Committee minutes reflect sufficient analysis and follow-up of EOC inspection findings and track identified deficiencies to resolution.

**2.** We recommended that processes be strengthened to ensure that patient care areas are clean and that compliance be monitored.

**3.** We recommended that processes be strengthened to ensure that the hazardous materials inventory is current.

[1] VHA Directive 2009-026, *Location, Selection, Installation, Maintenance, and Testing of Emergency Eyewash and Shower Equipment,* May 13, 2009.
[2] VHA Handbook 1176.01, *Spinal Cord Injury and Disorders (SCI/D) System of Care,* February 28, 2011.

**4**. We recommended that processes be strengthened to ensure that hazard assessments are completed in the dental laboratory and the ED and that emergency eyewash stations are added if needed.

**5.** We recommended that processes be strengthened to ensure that required SCI outpatient clinic staff are assigned and receive SCI-specific training and that compliance with training requirements be monitored.

## 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. |
| | Patients were notified of the diagnostic test results within the required timeframe. |
| | Patients who had biopsies were notified within the required timeframe. |
| | Patients were seen in surgery clinic within the required timeframe. |
| | The facility complied with any additional elements required by local policy. |

Positive CRC Screening Test Result Notification. VHA requires that patients receive notification of CRC screening test results within 14 days of the laboratory receipt date for fecal occult blood tests or the test date for sigmoidoscopy or double contrast barium enema and that clinicians document notification.[3] Seven 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.[4] Six 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.[5] Five of the 20 patients who had positive screening test results had not received diagnostic testing as of September 13, 2012. The following are the reasons patients did not receive diagnostic testing:

- The facility did not initiate two gastrointestinal consults.
- The facility did not initiate fee-basis care.

[3] VHA Directive 2007-004, *Colorectal Cancer Screening*, January 12, 2007 (corrected copy).
[4] VHA Directive 2007-004.
[5] VHA Directive 2007-004.

- The patient requested an appointment later in the year, but the facility did not schedule an appointment.
- The facility cancelled the gastrointestinal consult.

## Recommendations

**6.** 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.

**7.** 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.

**8.** We recommended that processes be strengthened to ensure that patients with positive CRC screening test results receive diagnostic testing within the required timeframe and that the facility evaluate the five cases to determine what further actions may be warranted.

## Coordination of Care

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

We reviewed 13 HF patients' EHRs and relevant documents and interviewed key employees. The areas marked as noncompliant in the table below needed improvement. Details regarding the findings 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. |
| X | Initial post-discharge follow-up appointments were scheduled within the providers' recommended timeframes. |
| X | The facility complied with any additional elements required by VHA or local policy. |

Discharge Medications. The JC's National Patient Safety Goals require the safe use of medications and stress the importance of maintaining and communicating accurate patient medication information. In two EHRs, medications ordered at discharge did not match those listed in patient discharge instructions.

Follow-Up Appointments. VHA requires that discharge instructions include recommendations regarding the initial follow-up appointment.[6] Although provider discharge instructions requested specific follow-up appointment timeframes, five appointments were not scheduled as requested.

Discharge Summary. VHA requires that discharge summaries contain certain elements, such as discharge medications.[7] None of the discharge summaries included discharge medications.

### Recommendations

**9.** We recommended that processes be strengthened to ensure that medications ordered at discharge match those listed on patient discharge instructions.

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

**11.** We recommended that processes be strengthened to ensure that discharge summaries include discharge medications.

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

## MH Treatment Continuity

The purpose of this review was to evaluate the facility's compliance with VHA requirements related to MH patients' transition from the inpatient to outpatient setting, including follow-up after discharge.

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

Outpatient Follow-Up. VHA requires that all patients discharged from inpatient MH receive outpatient follow-up from a MH provider within 7 days of discharge and that if this contact is by telephone, an in-person or telemental health evaluation must occur within 14 days of discharge.[8] Six of the 20 patients who were not on the high risk for suicide list did not receive outpatient MH follow-up within 7 days of discharge nor did they receive an in-person or telemental health appointment within 14 days of discharge. The facility made multiple attempts to contact five of those six patients. Additionally, 2 patients who were contacted by telephone within 7 days of discharge did not have an in-person or telemental health evaluation within 14 days.

Follow-Up for High Risk for Suicide Patients. VHA requires that patients discharged from inpatient MH who are on the high risk for suicide list be evaluated at least weekly during the first 30 days after discharge.[9] Nine of the 10 patients who were on the high risk for suicide list did not receive MH follow-up during the last 2 weeks of the 30-day timeframe. MH managers told us that the Suicide Prevention Coordinator position had been vacant until recently. Other MH staff members had rotated responsibility for suicide prevention activities in the interim.

Contact Attempts. VHA requires MH employees to document efforts to follow up with patients who do not keep scheduled MH appointments.[10] For two of the nine patients

[8] VHA Handbook 1160.01, *Uniform Mental Health Services in VA Medical Centers and Clinics,* September 11, 2008.
[9] Principal Deputy Under Secretary for Health and Deputy Under Secretary for Health for Operations and Management, "Patients at High-Risk for Suicide," memorandum, April 24, 2008.
[10] VHA Handbook 1160.01 and VHA Directive 2010-027, *VHA Outpatient Scheduling Processes and Procedures,* June 9, 2010.

who failed to keep their scheduled MH appointments, we did not find documentation of follow-up attempts.

### Recommendations

**12.** We recommended that processes be strengthened to ensure that all discharged MH patients who are not on the high risk for suicide list receive follow-up within the specified timeframes and that compliance be monitored.

**13.** 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 be monitored.

**14.** We recommended that processes be strengthened to ensure that attempts to follow up with patients who fail to keep their MH appointments are initiated and documented and that compliance be monitored.

## Polytrauma

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

We reviewed relevant documents, 10 EHRs of patients with positive TBI results, and 7 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 |
|---|---|
| X | 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. |
| X | Employees involved in polytrauma care were properly trained. |
| | Case Managers provided frequent, timely communication with hospitalized polytrauma patients. |
| | The interdisciplinary team coordinated inpatient care planning and discharge planning. |
| | Patients and their family members received follow-up care instructions at the time of discharge from the inpatient unit. |
| | Polytrauma-TBI System of Care facilities provided an appropriate care environment. |
| | The facility complied with any additional elements required by VHA or local policy. |

Timely Consult Requests. VHA requires that patients with positive TBI screening results be contacted to schedule a comprehensive evaluation within 5 days of receipt of the consult.[11] Three patients were contacted to schedule the evaluations; however, the contacts were not timely. For the remaining seven patients, the designated clinical service had not responded to the consultation requests even though the consults were more than 60 days old at the time of our visit.

Timely Evaluations. VHA requires that patients with positive TBI screening results have a comprehensive TBI evaluation within 30 days of the positive screening.[12] One patient had moved away. Seven of the 9 remaining patients did not receive comprehensive

[11] 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.
[12] VHA Directive 2010-012.

evaluations. One of the two patients who did receive a comprehensive evaluation did not receive it timely. Polytrauma clinic managers told us that they had more than 300 pending consults for comprehensive TBI evaluations.

Training. VHA requires that patients with positive TBI screening results at a Level IV site be offered further evaluation and treatment by clinicians with expertise in the area of TBI.[13] The facility had been formally designated as a Level IV site until August 3, 2012, when the facility's alternate plan to complete comprehensive TBI evaluations and provide specified services above the Level IV designation was approved. A physiatrist who conducted comprehensive TBI evaluations had not completed training in the TBI protocol as required by policy and outlined in the alternate plan. In addition, the facility was unable to provide documentation that other clinical support staff, such as designated occupational and speech therapy staff, had specialized TBI training or expertise.

## Recommendations

**15.** We recommended that processes be strengthened to ensure that the designated clinical service respond to consultation requests for TBI comprehensive evaluations within the required timeframe.

**16.** We recommended that processes be strengthened to ensure that all patients with positive TBI screening results receive a comprehensive evaluation within the required timeframe.

**17.** We recommended that the facility comply with polytrauma training requirements.

[13] VHA Directive 2010-012.

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

| Noncompliant | Areas Reviewed (continued) |
|---|---|
| | 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. |

Inpatient Evaluation Data. VHA expects that the senior managers discuss the data from the Inpatient Evaluation Center at a senior-level committee and document the discussion in the meeting minutes.[14] There was no evidence over the past 12 months that senior managers had discussed the data at a senior-level committee.

FPPE. VHA requires that the results from FPPEs be reported to the Medical Executive Committee for consideration in making the recommendation on privileges for newly hired licensed independent practitioners.[15] We reviewed the profiles of 10 newly hired licensed independent practitioners and found that 2 FPPEs were not completed. In addition, results of the eight completed FPPEs were not reported to the Medical Executive Committee.

EHR Review. VHA requires facilities to have an EHR Committee that provides oversight of EHR quality reviews, which includes analyzing aggregated data.[16] The reviews must include a representative sample of charts from each service or program to ensure that appropriate documentation is occurring. We found that some clinical services did not provide the required quality review information to the EHR Committee, and as a result, the committee could not provide consistent oversight and coordination and could not analyze or trend aggregated data.

VHA requires facilities to monitor the copy and paste functions.[17] The facility did not monitor the copy and paste functions in the EHR.

## Recommendations

**18.** We recommended that senior managers discuss the data from the Inpatient Evaluation Center at a senior-level committee and document the discussion in the committee's meeting minutes.

**19.** We recommended that processes be strengthened to ensure that FPPEs are completed for all newly hired licensed independent practitioners and that results are consistently reported to the Medical Executive Committee.

**20.** We recommended that processes be strengthened to ensure that clinical service EHR quality reviews are completed and results forwarded to the EHR Committee and

[14] Deputy of Quality Management in VHA for Operations and Management, "Evaluation of Quality Management in VHA Facilities FY2010," memorandum, February 23, 2011.
[15] VHA Handbook 1100.19, *Credentialing and Privileging,* November 14, 2008.
[16] VHA Handbook 1907.01.
[17] VHA Handbook 1907.01.

that the EHR Committee provides consistent oversight, coordination, and evaluation of EHR quality reviews.

**21**. We recommended that processes be strengthened to ensure that the copy and paste functions are 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 Result Management. When glucose values are determined to be critical, the facility requires the employee performing the test to repeat testing. If the result of the repeated test is determined to be critical, a clinical laboratory glucose test is to be ordered to verify the result, and the physician is to be notified. For 7 of the 10 patients who had critical test results, staff did not complete all required actions. Five of the seven patients did not have repeat testing, and three of the seven patients did not have clinical laboratory verification. Additionally, three of the seven EHRs did not reflect physician notification of the critical test results.

### Recommendation

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

## 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, 10 EHRs, and 8 training/competency records, 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 |
|---|---|
| | Staff completed competency-based education/training prior to assisting with or providing moderate sedation. |
| | 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. |
| X | The facility complied with any additional elements required by local policy. |

Pre-Sedation Assessment Documentation. Local policy allows sedation nurses to complete pre-sedation assessments and have the provider sign. None of the EHRs included provider signatures for the pre-sedation assessments completed by nursing staff.

### Recommendation

**23.** We recommended that processes be strengthened to ensure that providers sign all pre-sedation assessments completed by nursing staff.

# Review Activity Without Recommendations

## Nurse Staffing

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

We reviewed relevant documents and nine training files and interviewed key employees. Additionally, we reviewed the actual nursing hours per patient day for one acute care unit (3C) for 30 randomly selected days (holidays, weekdays, and weekend days) between October 2011 and March 2012. The table below details the areas reviewed. The facility generally met requirements. We made no recommendations.

| Noncompliant | Areas Reviewed |
|---|---|
| | The unit-based expert panels followed the required processes. |
| | The facility expert panel followed the required processes. |
| | Members of the expert panels completed the required training. |
| | The facility completed the required steps to develop a nurse staffing methodology by the deadline. |
| | 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. |

# 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 23–34 for the full text of the Directors' comments.) We will follow up on the planned actions until they are completed.

| Facility Profile[18] | | |
|---|---|---|
| **Type of Organization** | Medical center – non tertiary care | |
| **Complexity Level** | 2 | |
| **VISN** | 6 | |
| **Community Based Outpatient Clinics** | Wilmington, NC<br>Jacksonville, NC<br>Robeson, NC<br>Hamlet, NC | |
| **Veteran Population in Catchment Area** | 283,450 | |
| **Type and Number of Total Operating Beds:**<br>• **Hospital, including Psychosocial RRTP** | 60 | |
| • **CLC/Nursing Home Care Unit** | 69 | |
| **Medical School Affiliation(s)** | The University of North Carolina at Chapel Hill | |
| • **Number of Residents** | 7 | |
| | **Current FY (through June 2012)** | **Prior FY (2011)** |
| **Resources (in millions):** | | |
| • **Total Medical Care Budget** | $235.4 | $202.8 |
| • **Medical Care Expenditures** | $186.4 | $202.8 |
| **Total Medical Care Full-Time Employee Equivalents** | 1,158.3 | 1,085.2 |
| **Workload:** | | |
| • **Number of Station Level Unique Patients** | 49,090 | 49,831 |
| • **Inpatient Days of Care:** | | |
| o **Acute Care** | 10,743 | 13,591 |
| o **CLC/Nursing Home Care Unit** | 13,483 | 17,219 |
| **Hospital Discharges** | 2,143 | 2,491 |
| **Total Average Daily Census (including all bed types)** | 88 | 84 |
| **Cumulative Occupancy Rate (in percent)** | 68.2 | 65.1 |
| **Outpatient Visits** | 357,869 | 417,241 |

[18] All data provided by facility management.

# VHA Satisfaction Surveys

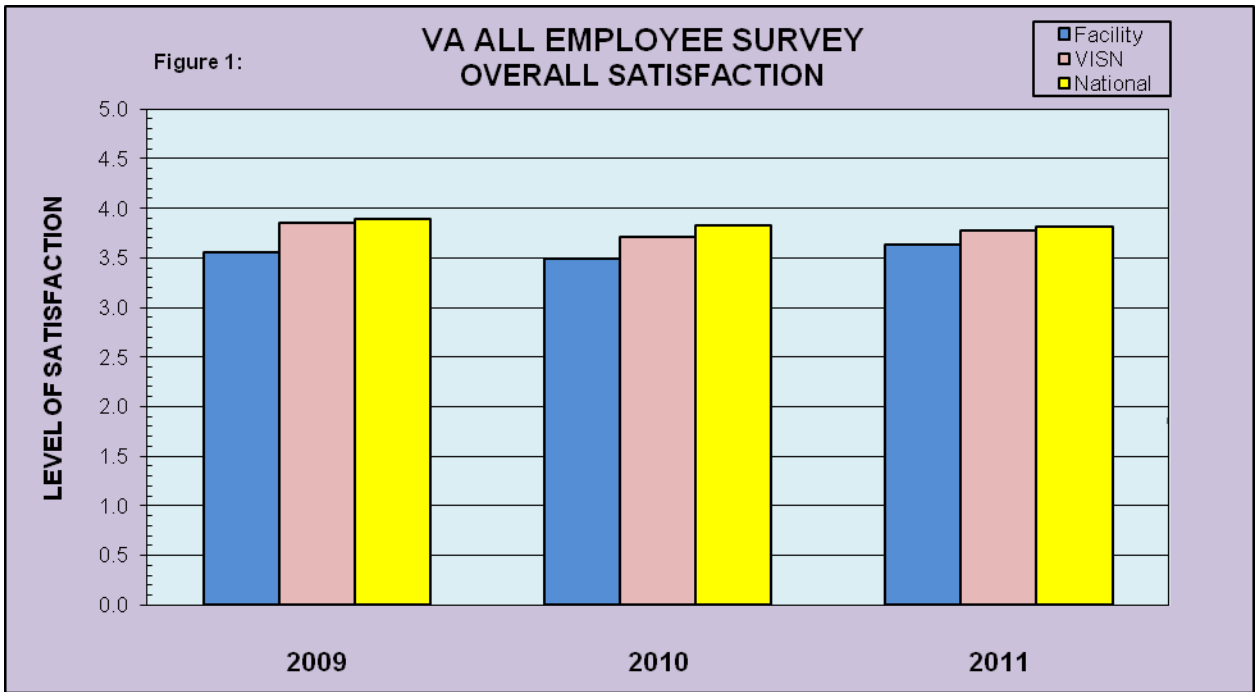
VHA has identified patient and employee satisfaction scores as significant indicators of facility performance. Patients are surveyed monthly. Table 1 below shows facility, VISN, and VHA overall inpatient and outpatient satisfaction scores for quarters 3 and 4 of FY 2011 and quarters 1 and 2 of FY 2012.

**Table 1**

| | Inpatient Scores | | Outpatient Scores | | | |
|---|---|---|---|---|---|---|
| | FY 2011 | FY 2012 | FY 2011 | | FY 2012 | |
| | Inpatient Score Quarters 3–4 | Inpatient Score Quarters 1–2 | Outpatient Score Quarter 3 | Outpatient Score Quarter 4 | Outpatient Score Quarter 1 | Outpatient Score Quarter 2 |
| Facility | 52.4 | 48.7 | 43.6 | 34.4 | 31.2 | 44.8 |
| VISN | 62.5 | 59.5 | 57.8 | 48.8 | 49.7 | 49.7 |
| VHA | 64.1 | 63.9 | 54.2 | 54.5 | 55.0 | 54.7 |

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.[19] 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, 2008, and June 30, 2011.[20]

**Table 2**

| | Mortality | | | Readmission | | |
|---|---|---|---|---|---|---|
| | Heart Attack | Congestive HF | Pneumonia | Heart Attack | Congestive HF | Pneumonia |
| Facility | ** | 10.4 | 13.0 | ** | 23.1 | 18.5 |
| U.S. National | 15.9 | 11.3 | 11.9 | 19.8 | 24.8 | 18.4 |

** The number of cases is too small (fewer than 25) to reliably tell how well the facility is performing.

[19] 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.

[20] 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:** November 13, 2012

**From:** Director, VA Mid-Atlantic Health Care Network (10N6)

**Subject:** **CAP Review of the Fayetteville VA Medical Center, Fayetteville, NC**

**To:** Director, Atlanta Office of Healthcare Inspections (54AT)

Director, Management Review Service (VHA 10AR MRS)

1. I would like to express my appreciation to the Office of Inspector General (OIG) Survey Team for their professional and comprehensive review.

2. I have reviewed the draft report for the Fayetteville NC VA Medical Center, and concur with the findings and recommendations.

3. Please express my gratitude to the Survey Team for their professionalism and assistance to us in our continuing efforts to improve the care we provide to our veterans. If there are further questions, please contact Lisa Shear, VISN 6 QMO, at 919-956-5541.

*(original signed by:)*
DANIEL F. HOFFMANN, FACHE

# Facility Director Comments

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

**Date:** November 6, 2012

**From:** Director, Fayetteville VA Medical Center (565/00)

**Subject:** **CAP Review of the Fayetteville VA Medical Center, Fayetteville, NC**

**To:** Director, VA Mid-Atlantic Health Care Network (10N6)

Attached please find the facility concurrences and responses to each of the findings from the review.

If you have additional questions or need further information, please contact Damaris A. Reyes, Chief Performance Improvement at 910-822-7091.

*(original signed by:)*
ELIZABETH GOOLSBY

# Comments to OIG's Report

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

**OIG Recommendations**

**Recommendation 1.** We recommended that processes be strengthened to ensure that EOC Committee minutes reflect sufficient analysis and follow-up of EOC inspection findings and track identified deficiencies to resolution.

Concur

Target date for completion: January 31, 2013

The initial revision of the EOC minutes was completed on October 24th. The minutes now include identified deficiencies, progress towards resolution, and the tracking of items until closure. The EOC chair is utilizing a tracking tool for open items to ensure they are tracked until closure and a checklist to review the minutes to ensure that they contain required documented elements to improve the quality and compliance of the minutes with standards and regulations. The Fayetteville EOC minutes will be reviewed on a monthly basis by a VISN program official (QMO, Accreditation Specialist, or other Subject Matter Expert) to ensure that they are meeting their improvement goals and necessary compliance. Feedback will be given within one week of receipt of the facility minutes, and suggestions implemented by the facility EOC committee with the next set of minutes. EOC minutes will continue to be submitted to the Executive Leadership Board monthly for facility leadership oversight.

**Recommendation 2.** We recommended that processes be strengthened to ensure that patient care areas are clean and that compliance be monitored.

Concur

Target date for completion: October 30, 2012

The facility has regularly scheduled cleaning daily of inpatient clinical areas, daily of outpatient clinical areas, and bi-weekly of administrative areas. Specialty areas, such as OR, pharmacy, etc, are assigned specific cleaning personnel and are cleaned according to the specialized requirements and frequency of their areas.

On September 20, 2012, the facility began using the VHA Environmental Protection Service (EPS) checklists that were modified for each inpatient, clinical and administrative type of areas to monitor the cleanliness of the areas. Validation instruments were placed in each of the areas and are reviewed daily. A terminal cleaning log utilizes the 3M Clean trace system to validate the cleanliness of inpatient units. When an inpatient room is terminally cleaned post discharge, it is checked with this system. The clinical areas are inspected weekly for cleanliness by and EMS

supervisor or chief utilizing an inspection sheet from the EPS site. The data is analyzed for opportunities for improvement and trends, prior to the reports going forward to EOC committee for monthly reporting and oversight by the Executive Leadership Board.

**Recommendation 3.** We recommended that processes be strengthened to ensure that the hazardous materials inventory is current.

Concur

Target date for completion: October 30, 2012

As of October 30, 2012, 100% of areas (48/48) have submitted an updated hazardous materials inventory. To ensure the inventory is kept current, the IH will conduct weekly random rounds to verify that the inventory is accurate and that no unauthorized chemicals are in the worksite (Target >90%). The IH will check 4 of these inventories per week so that by end of the quarter, all areas will have been reviewed. The results will be reported monthly to the Environment of Care committee, with oversight of the Executive Leadership Board, until closure of the recommendation.

**Recommendation 4.** We recommended that processes be strengthened to ensure that hazard assessments are completed in the dental laboratory and the ED and that emergency eyewash stations are added if needed.

Concur

Target date for completion: November 16, 2012

On September 20, 2012, risk assessments were completed in the Dental Lab and the Emergency Department with input from the end users and the Safety Office staff. An updated hazardous materials inventory for these areas was completed on October 28, 2012. The inventory form was updated to include information related to the container size, number of containers and existence of corrosives within the service area. The assessment at the Dental Lab concluded a RAC (risk assessment code) of 3, indicating the station is optional. However, based on end user input and the 2012 Guide Book, an eye wash station was installed on October 27, 2012. This station is fully operational and in use. The 2012 CEOSH Guide Book recommends an eyewash station for the ED. The ED risk assessment was presented to the Environment of Care Committee on October 9, 2012 and the decision to keep the existing eyewash was approved. In-service training was provided to the Emergency Room staff on October 11, 2012. Additional training sessions have been coordinated with the ER Nurse Manager and Dental Service to complete training for the remaining staff by November 16, 2012. The corrective actions have been reported to the EOC committee and overseen by the Executive Leadership Board.

**Recommendation 5.** We recommended that processes be strengthened to ensure that required SCI outpatient clinic staff are assigned and receive SCI-specific training and that compliance with training requirements be monitored.

Concur

Target date for completion: October 30, 2012

As of September 24, 2012, all SCI team members have been identified and assigned. The required training for SCI team members was identified per VHA Handbook 1176. As of October 30, 2012, all required training has been completed by all members of the team. The training compliance of the SCI team has been added as a regular report element of the PM&R Service to the Medical Executive Board with oversight by the Executive Leadership Board.

**Recommendation 6.** 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: November 15, 2012

Providers received additional training on the CRC screening protocols to notify patients within fourteen days and of the requirement to document a plan of care for positive FOBT results. All training is expected to be completed by November 15th, 2012. New providers will be trained on colorectal screening requirements within 14 days of EOD. The validation of the process of patient notification has been revised so that the Chief of Primary Care Service and the GI Nurse consultant (and surrogates) are sent a list of all positive FOBT twice a week by the laboratory. This list is then compared to the provider's documentation in CPRS, to ensure timely contact with the patient was made and documented (Target 90%). Compliance with this process will be reported to the Medical Executive Board monthly with oversight by Executive Leadership Board until closure.

**Recommendation 7.** 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 15, 2012

Providers received additional training on the CRC requirements for documentation of follow-up plans for patients with positive FOBT results. The provider will submit a consult to GI service within time frame when a positive FOBT indicates the need for a colposcopy or other diagnostic procedure consult, which is documented in the patient's plan of care. If the patient states they have received a colorectal screening or

colonoscopy from a provider outside the VA, the provider or a team member of the PACT team will make attempts to acquire and review the documents and annotate this in the patient's medical record. The provider will document if no follow-up is indicated within the required timeframe. All training is expected to be completed by November 15, 2012. The validation of the documentation of a follow-up plan will be monitored by the Chief of Primary Care Service and the GI Nurse consultant (and surrogates) utilizing the list of all positive FOBT's from the laboratory. This list is compared to the provider's documentation in CPRS, to ensure the requirements were met and documented (Target 90%). Compliance with this process will be reported to the Medical Executive Board monthly with oversight by Executive Leadership Board until closure.

**Recommendation 8.** We recommended that processes be strengthened to ensure that patients with positive CRC screening test results receive diagnostic testing within the required timeframe and that the facility evaluate the five cases to determine what further actions may be warranted.

Concur

Target date for completion: October 30, 2012

The following process was implemented as of October 30, 2012. The GI service schedules patients for a pre screen exam and a colonoscopy to be conducted within 45 days of being consulted and the patient will be informed of the same. In the event the patient is unable to keep the appointment within the timeframe, that information will be documented in the medical record and a negotiated appointment will be offered to the patient. If the patient fails to present for the pre-screening, the GI service will attempt to contact the patient for education regarding the importance of the procedure. The discussion will be documented in the medical record. An appointment will be rescheduled if the patient agrees to the procedure or the consult will be discontinued if the patient declines. The Primary Care provider will be notified in either case. For patients that are in need of appropriate medical clearance due to additional comorbidities expedited referrals will be completed to ensure timely intervention. The validation of the receipt of appropriate diagnostic testing within the required timeframe will be monitored by the Chief of Primary Care Service and the GI Nurse consultant (and surrogates) utilizing the list of all positive FOBT's from the laboratory. This list is compared to the provider's documentation in CPRS, to ensure the requirements were met and documented (Target 90%). Compliance with this process will be reported to the Medical Executive Board monthly with oversight by Executive Leadership Board until closure.

A medical record review of the five patients that were identified as not having a diagnostic testing within the required timeframe was completed. All patients were contacted by October 30, 2012. Of these, four have been scheduled for a suitable diagnostic intervention and one has declined to have a colonoscopy. Patient education was completed and the refusing patient was advised of the potential outcomes of non

compliance with this medical advice. Appropriate documentation has been completed within the medical record.

**Recommendation 9.** We recommended that processes be strengthened to ensure that medications ordered at discharge match those listed on patient discharge instructions.

Concur

Target date for completion: October 30, 2012

As of October 30, 2012 all Hospitalists have been re-educated on the process of reviewing and verifying that the medications ordered at discharge match those in the discharge instructions. If a medication is added after the discharge instruction is signed, the provider will write an addendum to the note with additional instructions. New providers are educated on this requirement as they enter on duty.

A monitor of this process will be completed to ensuring the medications listed on the discharge instructions match the medications that were listed in the discharge orders. The Chief of Medicine will report compliance (Target 90%) with this process to the Medical Executive Board monthly with oversight by Executive Leadership Board until closure.

**Recommendation 10.** 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: November 1, 2012

As of November 1, 2012, patients and/or their surrogate will receive in writing a post hospital appointment during the discharge instruction teaching session. This appointment will be consistent with the timeframes requested by the discharging provider. Compliance of this process (Target 90%) will be monitored by comparing the physician order to the discharge appointment provided for all patients discharged from the facility with a primary diagnosis of CHF. Monthly compliance reports will be provided by the Section Chief of Ward Administration/Health Administration Services to the Medical Executive Board with oversight by the Executive Leadership Board.

**Recommendation 11.** We recommended that processes be strengthened to ensure that discharge summaries include discharge medications.

Concur

Target date for completion: October 30, 2012

On October 16, 2012, the provider discharge summary template was revised to included discharge medications. To educate providers on the update, a paper copy was given to

each hospitalist and the update was reviewed. Information was also disseminated to the hospitalists via electronic message. This process will be monitored that the medications listed in the discharge instructions match the medications listed in the discharge summary (Target 90%). The Chief of Medicine will report the compliance to the Medical Executive Board monthly with oversight by the Executive Leadership Board.

**Recommendation 12.** We recommended that processes be strengthened to ensure that all discharged MH patients who are not on the high risk for suicide list receive follow-up within the specified timeframes and that compliance be monitored.

Concur

Target date for completion: October 30, 2012

The process of all discharged mental health patients, who are not on the high risk for suicide list, receiving follow-up within the specified timeframes has been implemented. As of October 30, 2012, all required training has been completed by members of the team. Daily audits of discharge patients are being conducted to ensure Veterans have a scheduled appointment within 7 days of discharge. Designated staff has been assigned responsibility to make telephone contact with discharged Veterans within 48 hours of discharge to re-enforce and remind Veteran of the scheduled follow-up appointment. Performance will be monitored (Target 90%) by Chief of MHSL and reported to The Medical Executive Board monthly with oversight by the Executive Leadership Board.

**Recommendation 13.** 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 be monitored.

Concur

Target date for completion: October 30, 2012

Veterans identified as high risk are entered on spreadsheet maintained by Suicide Prevention. The Suicide Prevention staff ensure that the veterans are contacted weekly for follow up and update the spread sheet. Performance will be monitored by the Chief of MHSL (Target 90%) and reported to the Medical Executive Board with oversight by the Executive Leadership Board.

**Recommendation 14.** We recommended that processes be strengthened to ensure that attempts to follow up with patients who fail to keep their MH appointments are initiated and documented and that compliance be monitored.

Concur

Target date for completion: October 15, 2012

By October 15, 2012, all of the Mental Health clinical staff were re-educated on the MH service policy on follow-up of No Shows. Weekly audits to ensure documentation of follow-up attempts are occurring. Performance will be monitored by Chief of MHSL (Target 90%) and reported to the Medical Executive Board with oversight by the Executive Leadership Board.

**Recommendation 15.** We recommended that processes be strengthened to ensure that the designated clinical service respond to consultation requests for TBI comprehensive evaluations within the required timeframe.

Concur

Target date for completion: December 31, 2012

Facility leadership has authorized the required staffing for level III poly-trauma program and aggressive recruitment is in process. The current poly-trauma staff have developed a process by which all patients referred to the program will be contacted within the timeframe and will be tracked using the consult package. Consults will be monitored by the Chief of PM&R and compliance with the timeframes (target 90%) will be reported monthly to the Medical Executive Board, with oversight by the Executive Leadership Board.

**Recommendation 16.** We recommended that processes be strengthened to ensure that all patients with positive TBI screening results receive a comprehensive evaluation within the required timeframe.

Concur

Target date for completion: March 31, 2013

Facility leadership has authorized required staffing for level III poly-trauma program and aggressive recruitment is in process. The Chief of Staff's office, in concurrence with Chief of PM&RS have outlined a plan to evaluate all veterans that are awaiting a second level evaluation by March 31, 2013. The outlined plan includes a new clinic to begin with approximately 44 slots per week to begin at or by November 19, 2012, and have already started a scheduling process so that all backlogged patients will have future appointments and expect completion of this by November 30, 2012. This process will create 792 slots by March 31, 2012 which would be projected data of completion and will address the backlog and allow the facility to stay current with day-to-day work. Consults will be monitored by the Chief of PM&R and compliance with the timeframes (target 90%) will be reported monthly to the Medical Executive Board, with oversight by the Executive Leadership Board.

**Recommendation 17.** We recommended that the facility comply with polytrauma training requirements.

Concur

Target date for completion: October 30, 2012

All required training has been completed by all members of the team. Training compliance and requirements have been added as a recurring report. New team members will be educated with their service level orientation as they enter on duty. The education compliance (Target 90%) will be reported to the Medical Executive Board with oversight by the Executive Leadership Board.

**Recommendation 18.** We recommended that senior managers discuss the data from the Inpatient Evaluation Center at a senior-level committee and document the discussion in the committee's meeting minutes.

Concur

Target date for completion: September 28, 2012

As of September 2012, the discussion of the Inpatient Evaluation Center report was added as a standing agenda item of the Medical Executive Board that is chaired by the Chief of Staff. Documentation of this discussion is captured in the committee minutes. The Executive Leadership Board provides oversight to the Medical Executive Board.

**Recommendation 19.** We recommended that processes be strengthened to ensure that FPPEs are completed for all newly hired licensed independent practitioners and that results are consistently reported to the Medical Executive Committee.

Concur

Target date for completion: January 31, 2013

As of September 30, 2012, a tool was developed and is in use to facilitate tracking of the entire FPPE process to completion. This tool will be used for new hires in addition to those providers that were previously identified as not being compliant during the comprehensive OIG-CAP review. A standard operating procedure is being written that will outline this process for our facility. Upon completion and approval by the MEB, Clinical Service Chiefs who participate in the FPPE process will be trained. The compliance (Target 90%) of FPPE results being reported to the Medical Executive Board will be overseen by the Executive Leadership Board.

**Recommendation 20.** We recommended that processes be strengthened to ensure that clinical service EHR quality reviews are completed and results forwarded to the

EHR Committee and that the EHR Committee provides consistent oversight, coordination, and evaluation of EHR quality reviews.

Concur

Target date for completion: March 31, 2013

All service chiefs have been directed by Chief of Staff that the medical record reviews must be submitted on time and complete with all information. A detailed reporting plan, which clearly specifies the requirements, has been shared with the service chiefs and committee representatives.

A decision has been made to have each service report monthly, rather than quarterly, in order to gather more data in a shorter time period, and to ensure that each service is producing useful and meaningful data (Target 90%). These monthly reports will be submitted to the Medical Record Committee with oversight by the Medical Executive Board until closure, at which time the committee will evaluate the reporting frequency.

**Recommendation 21.** We recommended that processes be strengthened to ensure that copy and paste functions are monitored.

Concur

Target date for completion: March 31, 2012

All service chiefs have been directed by Chief of Staff that the medical record reviews must be submitted on time and be complete with all information, including the mandatory monitor of inappropriate use of copy/paste. A detailed reporting plan, which clearly specifies the requirements, has been shared with the service chiefs and committee representatives.

A decision has been made to have each service report monthly, rather than quarterly, in order to gather more data in a shorter time period, and to ensure that each service is producing useful and meaningful data (Target 90%). These monthly reports will be submitted to the Medical Record Committee with oversight by the Medical Executive Board until closure, at which time the committee will evaluate the reporting frequency.

**Recommendation 22.** 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: December 31, 2012

A hyper/hypoglycemia nursing protocol was developed that includes required steps to be taken for the POCT critical blood glucose values >500 or <50. The protocol was approved by the Medical Executive Board on September 19, 2012. Training was completed for all inpatient direct care nursing staff on November 1, 2012. Compliance

with the protocol and actions in response to critical results are being monitored daily. This is completed with the assistance of laboratory services that provides a daily list of all patients who have had blood glucose POCT. The effectiveness of this monitor (Target 90%) will be reported to the Nurse Executive Council & the Medical Executive Board with oversight of the Executive Leadership Board.

**Recommendation 23.** We recommended that processes be strengthened to ensure that providers sign all pre-sedation assessments completed by nursing staff.

Concur

Target date for completion: Completed October 8, 2012

The moderate sedation form was revised to include the physician's signature on the same form that the registered nurse completes the pre sedation assessment on. This was completed on July 16, 2012. All moderate sedation staff were trained during the week of July 22–27, 2012 and the implementation of the new form went into effect on August 1, 2012.

Compliance (Target 90%) with the physician signature being present on the same form as the nursing pre-sedation assessments will be reported to the Medical Executive Board with oversight by the Executive Leadership Board. As of October 2012, the physician's signature was present on over 99% of the audited assessments.

# OIG Contact and Staff Acknowledgments

| | |
|---|---|
| **Contact** | For more information about this report, please contact the OIG at (202) 461-4720. |
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