Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 12-03741-61

Combined Assessment Program Review of the VA Maine Healthcare System Augusta, Maine

December 12, 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
CS	controlled substances
EHR	electronic health record
EOC	environment of care
facility	VA Maine Healthcare System
FY	fiscal year
HPC	hospice and palliative care
MH	mental health
NA	not applicable
NC	noncompliant
OIG	Office of Inspector General
PCCT	Palliative Care Consult Team
PRC	Peer Review Committee
QM	quality management
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

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Executive Summary

Review Purpose: The purpose of the review was to evaluate selected health care facility operations, focusing on patient care quality and the environment of care, and to provide crime awareness briefings. We conducted the review the week of October 15, 2012.

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

- Medication Management – Controlled Substances Inspections
- Long-Term Home Oxygen Therapy
- Nurse Staffing
- Preventable Pulmonary Embolism

The facility's reported accomplishments were improving veteran-centered care in the mental health clinic and high scores within the Hospice and Palliative Care Program.

Recommendations: We made recommendations in the following three activities:

Quality Management: Ensure that actions from peer reviews are reported to the Peer Review Committee, that electronic health record quality reviews are analyzed at least quarterly, and that corrective actions are consistently followed to resolution by quality management committees.

Environment of Care: Ensure that oxygen tanks are stored in a manner that distinguishes between empty and full tanks and that tanks are not stored near electrical circuit breaker panels. Perform required preventive maintenance on designated equipment in the physical therapy clinics.

Coordination of Care – Hospice and Palliative Care: Ensure that all non-hospice and palliative care staff receive end-of-life training.

Comments

The Veterans Integrated Service Network and Facility Directors agreed with the Combined Assessment Program review findings and recommendations and provided acceptable improvement plans. (See Appendixes C and D, pages 15–19, for the full text of the Directors' comments.) We will follow up on the planned actions until they 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 quality and the EOC.
- 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 compliance with requirements related to patient care quality and the EOC. In performing the review, we inspected selected areas, interviewed managers and employees, and reviewed clinical and administrative records. The review covered the following seven activities**:**

- QM
- EOC
- Medication Management – CS Inspections
- Coordination of Care – HPC
- Long-Term Home Oxygen Therapy
- Nurse Staffing
- Preventable Pulmonary Embolism

We have listed the general information reviewed for each of these activities. Some of the items listed may 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 2012 and FY 2013 through October 15, 2012, and was done in accordance with OIG standard operating procedures for CAP reviews. We also asked the facility to provide the current status on the recommendations we made in our previous CAP report (*Combined Assessment Program Review of the VA Maine Healthcare System, Augusta, Maine,* Report No. 11-01294-244, August 3, 2011). We made repeat recommendations in QM.

During this review, we presented crime awareness briefings for 32 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 248 responded. We shared survey results with facility managers.

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

Reported Accomplishments

Veteran-Centered Care in the MH Clinic

MH clinic staff and leadership use systems redesign methodologies to improve veteran-centered care. For example, using a VHA Support Service Center report, staff identify veterans who are most likely to "no show" for an appointment. Staff run the report daily and call veterans to remind them of their appointments. This has reduced the time spent on reminder calls from 10 hours per week to less than 1.5 hours per week, and the "no show" rate has reduced from 10 percent to 8 percent since the beginning of FY 2012. Staff have implemented other veteran-centered features in the clinic such as a children's area in the waiting room, contact number cards for veterans with walk-in appointments, and a paging system to notify veterans when providers are ready to meet with them.

HPC Program

Based on the Bereaved Family Survey, which is offered to loved ones following the death of a veteran in a VA facility, the HPC Program currently has the highest VA Performance Reporting and Outcomes Measurement to Improve the Standard of Care at End of Life rating in the nation. The facility had a score of 81 percent for quarter 3 of FY 2012 compared to the national mean of 58 percent and the goal of 65 percent. Additionally, the facility received a score of 83 percent for providing inpatients with either a palliative care consult or hospice admission prior to their death compared to the national goal of 55 percent.

The program includes an inpatient hospice unit and home hospice care. The inpatient unit, renovated in 2011, includes many home-like and veteran-centered features. Home hospice care allows veterans to receive care in the comfort of their homes with family and friends nearby. Program staff consists of 50 percent registered nurses and 44 percent nursing assistants, all of whom are certified in hospice and/or palliative care and are highly committed to their specialty.

Results and 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.[1]

We interviewed senior managers and key QM employees, and we evaluated meeting minutes, EHRs, and other relevant documents. The table below shows the areas reviewed for this topic. The areas marked as NC needed improvement. Items that did not apply to this facility are marked "NA."

NC	Areas Reviewed	Finding
	There was a senior-level committee/group responsible for QM/performance improvement, and it included the required members.	
	There was evidence that Inpatient Evaluation Center data was discussed by senior managers.	
X	Corrective actions from the protected peer review process were reported to the PRC.	Six months of PRC meeting minutes reviewed: • Of the eight actions expected to be completed, none were reported to the PRC. This is a repeat finding from the previous CAP review.
	Focused Professional Practice Evaluations for newly hired licensed independent practitioners complied with selected requirements.	
	Local policy for the use of observation beds complied with selected requirements.	
	Data regarding appropriateness of observation bed use was gathered, and conversions to acute admissions were less than 30 percent.	
	Staff performed continuing stay reviews of at least 75 percent of patients in acute beds.	
	Appropriate processes were in place to prevent incidents of surgical items being retained in a patient following surgery.	
	The cardiopulmonary resuscitation review policy and processes complied with requirements for reviews of episodes of care where resuscitation was attempted.	
X	There was an EHR quality review committee, and the review process complied with selected requirements.	Six months of EHR Committee meeting minutes reviewed: • There was no evidence that EHR quality reviews were analyzed at least quarterly.

NC	Areas Reviewed (continued)	Finding
	The EHR copy and paste function was monitored.	
	Appropriate quality control processes were in place for non-VA care documents, and the documents were scanned into EHRs.	
	Use and review of blood/transfusions complied with selected requirements.	
	CLC minimum data set forms were transmitted to the data center monthly.	
X	Overall, if significant issues were identified, actions were taken and evaluated for effectiveness.	• Corrective actions were not consistently followed to resolution by the Health Information Management Committee, Special Care Unit Committee, and the Systems Redesign Collaborative teams. This is a repeat finding from the previous CAP review.
	There was evidence at the senior leadership level that QM, patient safety, and systems redesign were integrated.	
	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 VHA or local policy.	

Recommendations

1. We recommended that processes be strengthened to ensure that actions from peer reviews are reported to the PRC.

2. We recommended that processes be strengthened to ensure that EHR quality reviews are analyzed at least quarterly.

3. We recommended that processes be strengthened to ensure that actions taken when data analyses indicated problems or opportunities for improvement are consistently followed to resolution by the Health Information Management Committee, Special Care Unit Committee, and the Systems Redesign Collaborative teams.

EOC

The purpose of this review was to determine whether the facility maintained a clean and safe health care environment in accordance with applicable requirements.[2]

We inspected the MH, hospice, and special care inpatient units and one medical/surgical unit. We also inspected the CLC, the emergency department, the women's health clinic, an ambulatory care clinic, and two physical therapy clinics. Additionally, we reviewed relevant documents and interviewed key employees and managers. The table below shows the areas reviewed for this topic. The areas marked as NC needed improvement. Items that did not apply to this facility are marked "NA."

NC	Areas Reviewed for General EOC	Finding
	EOC Committee minutes reflected sufficient detail regarding identified deficiencies, corrective actions taken, and tracking of corrective actions to closure.	
	An infection prevention risk assessment was conducted, and actions were implemented to address high-risk areas.	
	Infection Prevention/Control Committee minutes documented discussion of identified high-risk areas and follow-up on implemented actions and included analysis of surveillance activities and data.	
	The facility had a policy that detailed cleaning of equipment between patients.	
	Patient care areas were clean.	
	Fire safety requirements were met.	
X	Environmental safety requirements were met.	• Oxygen tanks in 7 of the 10 units/areas inspected were not stored in a manner that distinguished between empty and full tanks. • Oxygen tanks in an equipment room of one clinic were inappropriately stored near electrical circuit breaker panels.
	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 VHA, local policy, or other regulatory standards.	
	Areas Reviewed for the Women's Health Clinic	
	The Women Veterans Program Manager completed required annual EOC evaluations and tracked identified deficiencies to closure.	

	Areas Reviewed for the Women's Health Clinic (continued)	
	Fire safety requirements were met.	
	Environmental safety requirements were met.	
	Infection prevention requirements were met.	
	Medication safety and security requirements were met.	
	Patient privacy requirements were met.	
	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.	
	Areas Reviewed for Physical Medicine and Rehabilitation Therapy Clinics	
	Fire safety requirements were met.	
X	Environmental safety requirements were met.	• Six equipment items in the two physical therapy clinics did not receive required preventive maintenance.
	Infection prevention requirements were met.	
NA	Medication safety and security requirements were met.	
	Patient privacy requirements were met.	
	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.	

Recommendations

4. We recommended that processes be strengthened to ensure that oxygen tanks are stored in a manner that distinguishes between empty and full tanks and that oxygen tanks are not stored near electrical circuit breaker panels.

5. We recommended that processes be strengthened to ensure that required preventive maintenance is performed on designated equipment in the physical therapy clinics.

Medication Management – CS Inspections

The purpose of this review was to determine whether the facility complied with requirements related to CS security and inspections.[3]

We reviewed relevant documents and interviewed key employees. We also reviewed the training files of all CS Coordinators and 10 CS inspectors and inspection documentation from 12 CS areas, the inpatient and outpatient pharmacies, and the emergency drug cache. The table below shows the areas reviewed for this topic. Items that did not apply to this facility are marked "NA." The facility generally met requirements. We made no recommendations.

NC	Areas Reviewed	Finding
	Facility policy was consistent with VHA requirements.	
	VA police conducted annual physical security surveys of the pharmacy/pharmacies, and any identified deficiencies were corrected.	
	Instructions for inspecting automated dispensing machines were documented, included all required elements, and were followed.	
	Monthly CS inspection findings summaries and quarterly trend reports were provided to the facility Director.	
	CS Coordinator position description(s) or functional statement(s) included duties, and CS Coordinator(s) completed required certification and were free from conflicts of interest.	
	CS inspectors were appointed in writing, completed required certification and training, and were free from conflicts of interest.	
	Non-pharmacy areas with CS were inspected in accordance with VHA requirements, and inspections included all required elements.	
	Pharmacy CS inspections were conducted in accordance with VHA requirements and included all required elements.	
	The facility complied with any additional elements required by VHA or local policy.	

Coordination of Care – HPC

The purpose of this review was to determine whether the facility complied with selected requirements related to HPC, including PCCT, consults, and inpatient services.[4]

We reviewed relevant documents, 20 EHRs of patients who had PCCT consults (including 10 HPC inpatients), and 23 employee training records (8 HPC staff records and 15 non-HPC staff records), and we interviewed key employees. The table below shows the areas reviewed for this topic. The area marked as NC needed improvement. Items that did not apply to this facility are marked "NA."

NC	Areas Reviewed	Findings
	A PCCT was in place and had the dedicated staff required.	
	The PCCT actively sought patients appropriate for HPC.	
	The PCCT offered end-of-life training.	
X	HPC staff and selected non-HPC staff had end-of-life training.	• For the 15 non-HPC staff, there was no evidence that 10 had end-of-life training.
	The facility had a VA liaison with community hospice programs.	
	The PCCT promoted patient choice of location for hospice care.	
	The CLC-based hospice program offered bereavement services.	
	The HPC consult contained the word "palliative" or "hospice" in the title.	
	HPC consults were submitted through the Computerized Patient Record System.	
	The PCCT responded to consults within the required timeframe and tracked consults that had not been acted upon.	
	Consult responses were attached to HPC consult requests.	
	The facility submitted the required electronic data for HPC through the VHA Support Service Center.	
	An interdisciplinary team care plan was completed for HPC inpatients within the facility's specified timeframe.	
	HPC inpatients were assessed for pain with the frequency required by local policy.	
	HPC inpatients' pain was managed according to the interventions included in the care plan.	
	HPC inpatients were screened for an advanced directive upon admission and according to local policy.	
	The facility complied with any additional elements required by VHA or local policy.	

Recommendation

6. We recommended that processes be strengthened to ensure that all non-HPC staff receive end-of-life training.

Long-Term Home Oxygen Therapy

The purpose of this review was to determine whether the facility complied with requirements for long-term home oxygen therapy in its mandated Home Respiratory Care Program.[5]

We reviewed relevant documents and 33 EHRs of patients enrolled in the home oxygen program (including 1 patient deemed to be high risk), and we interviewed key employees. The table below shows the areas reviewed for this topic. Items that did not apply to this facility are marked "NA." The facility generally met requirements. We made no recommendations.

NC	Areas Reviewed	Findings
	There was a local policy to reduce the fire hazards of smoking associated with oxygen treatment.	
	The Chief of Staff reviewed Home Respiratory Care Program activities at least quarterly.	
	The facility had established a home respiratory care team.	
	Contracts for oxygen delivery contained all required elements and were monitored quarterly.	
	Home oxygen program patients had active orders/prescriptions for home oxygen and were re-evaluated for home oxygen therapy annually after the first year.	
	Patients identified as high risk received hazards education at least every 6 months after initial delivery.	
	NC high-risk patients were identified and referred to a multidisciplinary clinical committee for review.	
	The facility complied with any additional elements required by local policy.	

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 two selected units (acute care and long-term care).[6]

We reviewed relevant documents and 18 training records, and we interviewed key employees. Additionally, we reviewed the actual nursing hours per patient day for acute care unit 3S and CLC unit Veterans Village for 50 randomly selected days (holidays, weekdays, and weekend days) between October 1, 2011, and September 30, 2012. The table below shows the areas reviewed for this topic. Items that did not apply to this facility are marked "NA." The facility generally met requirements. We made no recommendations.

NC	Areas Reviewed	Findings
	The unit-based expert panels followed the required processes.	
	The facility expert panel followed the required processes and included all required members.	
	Members of the expert panels completed the required training.	
	The facility completed the required steps to develop a nurse staffing methodology by September 30, 2011.	
	The selected units' 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 VHA or local policy.	

Preventable Pulmonary Embolism

The purpose of this review was to evaluate the care provided to patients who were treated at the facility and developed potentially preventable pulmonary embolism.[7]

We reviewed relevant documents and 12 EHRs of patients with confirmed diagnoses of pulmonary embolism[a] January 1–June 30, 2012. The table below shows the areas reviewed for this topic. Items that did not apply to this facility are marked "NA." The facility generally met requirements. We made no recommendations.

NC	Areas Reviewed	Findings
	Patients with potentially preventable pulmonary emboli received appropriate anticoagulation medication prior to the event.	
	No additional quality of care issues were identified with the patients' care.	
	The facility complied with any additional elements required by VHA or local policy/protocols.	

[a] A sudden blockage in a lung artery usually caused by a blood clot that travels to the lung from a vein in the body, most commonly in the legs.

Facility Profile (Augusta/402) FY 2012 through September 2012 [b]	
Type of Organization	Secondary
Complexity Level	2-Medium complexity
Affiliated/Non-Affiliated	Affiliated
Total Medical Care Budget in Millions (through August 2012)	$265.0
Number of:	
• **Unique Patients**	39,859
• **Outpatient Visits**	411,047
• **Unique Employees**[c]	1,310
Type and Number of Operating Beds: (through August 2012)	
• **Hospital**	37
• **CLC**	72
• **MH**	20
Average Daily Census: (through August 2012)	
• **Hospital**	28
• **CLC**	68
• **MH**	15
Number of Community Based Outpatient Clinics	8
Location(s)/Station Number(s)	Caribou/402GA Rumford/402GC Saco/402GD Calais/402GB Lincoln/402 Portland/402HC Auburn/402GE Bangor/402HB
VISN Number	1

[b] All data is for FY 2012 through September 2012 except where noted.
[c] Unique employees involved in direct medical care (cost center 8200).

VHA Patient Satisfaction Survey

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	67.7	65.5	66.3	57.2	61.3	65.1
VISN	67.4	65.7	62.8	60.5	60.8	59.9
VHA	64.1	63.9	54.2	54.5	55.0	54.7

Hospital Outcome of Care Measures

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

Table 2

	Mortality			Readmission		
	Heart Attack	Heart Failure	Pneumonia	Heart Attack	Heart Failure	Pneumonia
Facility	**	11.5	11.6	**	24.5	19.7
U.S. National	15.5	11.6	12.0	19.7	24.7	18.5

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

[d] 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. Heart failure 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.

[e] 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 21, 2012

From: Director, VA New England Healthcare System (10N1)

Subject: **CAP Review of the VA Maine Healthcare System, Augusta, ME**

To: Director, Bedford Office of Healthcare Inspections (54BN)

I have reviewed and concur with the action plans included in the attached memorandum regarding Draft Report: Combined Assessment Program Review, VA Maine Healthcare System, Augusta, ME.

Sincerely,

(original signed by:)
Michael F. Mayo-Smith
Network Director, New England Healthcare System

Facility Director Comments

Department of Veterans Affairs **Memorandum**

Date: November 15, 2012

From: Director, VA Maine Healthcare System (402/00)

Subject: **CAP Review of the VA Maine Healthcare System, Augusta, ME**

To: Director, VA New England Healthcare System (10N1)

1. I would like to thank the Office of Inspector General (OIG) CAP Team for their very thorough review of the VA Maine Healthcare System. Their review highlighted many positive features of our delivery system, as well as a small number of areas for improvement.

2. I have reviewed and concurred with each of the OIG CAP recommendations, and action plans have been developed and are in the process of implementation.

3. Thank you for your service to Veterans.

RYAN S. LILLY, MPA
Medical Center Director
VA Maine Healthcare System

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 actions from peer reviews are reported to the PRC.

Concur

Target date for completion: 10/29/2012

Facility response:

1. A tracking log was implemented in March 2011 to track follow-up actions related to a completed peer review process. Per recommendation #1, the log will now be brought to the Peer Review Committee (PRC) for review with no less frequency than quarterly, commencing with the October 2012 PRC minutes.

Recommendation 2. We recommended that processes be strengthened to ensure that EHR quality reviews are analyzed at least quarterly.

Concur

Target date for completion: 12/31/2012

Facility response:

1. In collaboration with the Performance Improvement Board (PIB), the Chairman of the Health Information Management System (HIMS) Committee will send a memo out to all Clinical Service Chiefs of the requirement of electronic health record (EHR) point of care (POC) quality reviews within their service. A quarterly reporting schedule, mirroring the PIB service line reporting schedule will be re-issued to include the addition of POC quality reviews by clinical services. The POC EHR reviews will be reported the HIMS committee quarterly. The HIMS Committee will monitor EHR indicators for each clinical service. Monitoring and analyzing the POC EHR quality reviews will be captured in monthly minutes.

Recommendation 3. We recommended that processes be strengthened to ensure that actions taken when data analyses indicated problems or opportunities for improvement are consistently followed to resolution by the Health Information Management

Committee, Special Care Unit Committee, and the Systems Redesign Collaborative teams.

Concur

Target date for completion: 12/31/2012

Facility response:

1. The HIMS Committee, Special Care Unit Committee, and the Systems Redesign Collaborative Teams meeting minutes will be actively monitored and corrected as necessary on a monthly basis by Quality Management (QM) personnel until which compliance with recommendation # 3 is sustained. Sustained compliance will be achieved when meeting minutes demonstrate all that action items are followed to completion for six consecutive months.

2. The topic of follow through on committee meeting action items will be an agenda item on the Director's Bi-Monthly Supervisory Meeting 11/19/2012 to enhance overall compliance.

Recommendation 4. We recommended that processes be strengthened to ensure that oxygen tanks are stored in a manner that distinguishes between empty and full tanks and that oxygen tanks are not stored near electrical circuit breaker panels.

Concur

Target date for completion: 3/1/2013

Facility response:

1. VA Maine Environment of Care (EOC) Policy "Oxygen and Compressed Gas" will be reviewed at the bi-monthly Supervisor's Forum November 19, 2012. Supervisors will be informed of their responsibility of providing training to all their staff involved in the storage, transportation and safe use of compressed gases. Supervisors will be reminded that they need to assure the storage and handling procedures contained within the policy are being followed.

2. Between 12/3/2012 – 3/1/2013, all clinical areas that use oxygen tanks will have an unannounced visit by an adhoc EOC team to assess compliance with the Oxygen and Compressed Gas policy.

3. A system's redesign project lead by our Respiratory Therapy Supervisor/ Improvement Advisor is scheduled to occur in 12/2012. The expected outcome from the project will be a standardized, improved process for the facility staff to distinguish between empty vs. in-use vs. full oxygen tanks.

4. Regularly scheduled EOC rounds will continue to assess on-going compliance with our Oxygen Policy and any additional newly implemented process resulting from Systems Redesign project.

Recommendation 5. We recommended that processes be strengthened to ensure that required preventive maintenance is performed on designated equipment in the physical therapy clinics.

Concur

Target date for completion: 5/1/2013

Facility response:

1. The Rehabililtation Service Line Manager or designee will review the Medical Equipment Management Plan with physical therapy clinic staff emphasizing their responsibility to provide safe patient care related to medical equipment by 12/31/2012.

2. In addition to the regular checks prior to use, the Rehabilitation Service Line Manager will assign Rehabilitation staff to check an additional 5 pieces of equipment used less frequently and track any follow up actions necessary on the monthly inspection log for a six-month period ending 5/1/2013.

3. The Chief of Clinical Engineering will be reemphasizing the policy and procedures to clinical engineering staff to address the issue regarding labeling of medical equipment by 12/31/2012.

Recommendation 6. We recommended that processes be strengthened to ensure that all non-HPC staff receive end-of-life training.

Concur

Target date for completion: 5/1/2013

Facility response:

1. The Nurse Manager Hospice and Palliative Care (HPC) in conjunction with Palliative Coordinator will be developing an appropriate end-of-life power point training that will be loaded into our electronic mandatory training program, Talent Management System (TMS). All non-HPC staff will complete training by 5/1/2013. Training will be completed annually and upon hire for all non-HPC staff.

OIG Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the OIG at (202) 461-4720.
Contributors	Clarissa Reynolds, CNHA, MBA, Team Leader Annette Acosta, RN, MN Elaine Kahigian, RN, JD Frank Keslof, EMT, MHA Jeanne Martin, PharmD Claire McDonald, MPA Timothy Bond, Special Agent, Office of Investigations

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Endnotes

[1] References used for this topic included:
- VHA Directive 2009-043, *Quality Management System*, September 11, 2009.
- VHA Handbook 1050.01, *VHA National Patient Safety Improvement Handbook*, March 4, 2011.
- VHA Directive 2010-017, *Prevention of Retained Surgical Items*, April 12, 2010.
- VHA Directive 2010-025, *Peer Review for Quality Management*, June 3, 2010.
- VHA Directive 2010-011, *Standards for Emergency Departments, Urgent Care Clinics, and Facility Observation Beds*, March 4, 2010.
- VHA Directive 2009-064, *Recording Observation Patients*, November 30, 2009.
- VHA Handbook 1100.19, *Credentialing and Privileging*, November 14, 2008.
- VHA Directive 2008-063, *Oversight and Monitoring of Cardiopulmonary Resuscitative Events and Facility Cardiopulmonary Resuscitation Committees*, October 17, 2008.
- VHA Handbook 1907.01, *Health Information Management and Health Records*, August 25, 2006.
- VHA Directive 6300, Records Management, July 10, 2012.
- VHA Directive 2009-005, *Transfusion Utilization Committee and Program*, February 9, 2009.
- VHA Handbook 1106.01, *Pathology and Laboratory Medicine Service Procedures*, October 6, 2008.
- VHA Directive 2008-007, *Resident Assessment Instrument (RAI) Minimum Data Set (MDS)*, February 4, 2008.

[2] References used for this topic included:
- VHA Directive 2011-007, *Required Hand Hygiene Practices*, February 16, 2011.
- VHA Handbook 1330.01, Health Care Services for Women Veterans, May 21, 2010.
- VA National Center for Patient Safety, "Ceiling mounted patient lift installations," Patient Safety Alert 10-07, March 22, 2010.
- Various requirements of The Joint Commission, the Centers for Disease Control and Prevention, the Occupational Safety and Health Administration, the National Fire Protection Association, the American National Standards Institute, the Association for the Advancement of Medical Instrumentation, and the International Association of Healthcare Central Service Material Management.

[3] References used for this topic included:
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