Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 12-03740-75

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

January 3, 2013

Washington, DC 20420

To Report Suspected Wrongdoing in VA Programs and Operations
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(Hotline Information: http://www.va.gov/oig/hotline/default.asp)

Glossary

CAP	Combined Assessment Program
CBOC	community-based outpatient clinic
CLC	community living center
CS	controlled substances
ED	emergency department
EHR	electronic health record
EOC	environment of care
facility	Durham VA Medical Center
FY	fiscal year
HPC	hospice and palliative care
NA	not applicable
NC	noncompliant
OIG	Office of Inspector General
PCCT	Palliative Care Consult Team
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 eight activities. We made no recommendations in the following four activities:

- Environment of Care
- Medication Management – Controlled Substances Inspections
- Long-Term Home Oxygen Therapy
- Nurse Staffing

The facility's reported accomplishments were the successful pilot of a stand-alone outpatient dialysis unit, the availability of teleaudiology and teledermatology services for veterans outside of the facility's commuting area, and the use of the patient safety Simulation Center to identify performance opportunities.

Recommendations: We made recommendations in the following four activities:

Quality Management: Revise the local observation bed policy to include all required elements, and gather data about observation bed use. Ensure that the Critical Care Committee reviews each cardiopulmonary resuscitation event and that cardiopulmonary resuscitation event reviews include screening for clinical issues prior to the event. Revise the quality control policy for scanning to include image quality, linking of scanned documents to the correct record, and indexing the documents. Consistently scan the results of non-VA purchased diagnostic tests into electronic health records. Ensure required members from surgery and medicine attend Transfusion Committee meetings.

Coordination of Care – Hospice and Palliative Care: Ensure the Palliative Care Consult Team includes a dedicated administrative support person.

Preventable Pulmonary Embolism: Initiate protected peer review for the two identified patients, and complete any recommended review actions.

Construction Safety: Document contractor tuberculosis skin test results for all projects. Ensure that Construction Safety Committee minutes contain documentation of deficiencies and follow-up actions in response to unsafe conditions identified during inspections. Require that Material Safety Data Sheets for chemicals used in construction sites are located within the construction areas.

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 19–24, for the full text of the Directors' comments.) 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 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 eight activities:

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

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 2011, FY 2012, and FY 2013 through October 12, 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 Durham VA Medical Center, Durham, North Carolina,* Report No. 11-00035-191, June 10, 2011).

During this review, we presented crime awareness briefings for 329 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 194 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

Stand-Alone Outpatient Dialysis Unit

The facility is one of four VA facilities participating in a stand-alone outpatient dialysis clinic pilot program to provide convenient delivery of dialysis services to patients outside of the local commuting area. Historically, dialysis care has been provided at the facility or through a fee basis agreement with a private sector facility dialysis center. The stand-alone dialysis unit opened in June 2011 and provides daily outpatient dialysis services for up to 48 veterans within a 30-minute drive. The stand-alone clinic has received high patient satisfaction scores.

Patient Safety Simulation Center

The facility's Simulation Center applies high fidelity human simulation to improve the safety, reliability, and quality of medical care provided to patients in the perioperative, procedural, and acute care environments. The Simulation Center is overseen by an interdisciplinary team and has effectively been used as a training tool for performance improvement projects. The blame-free environment allows users to learn from their actions through teamwork, communication, and leadership principles. To date, more than 300 individuals, including physicians, nurses, respiratory therapists, chaplains, and other ancillary staff, have received training in the Simulation Center, resulting in system enhancements in the areas of basic life support performance, directional sign updates, emergency phone placements, paging systems, and physical access.

Teleaudiology and Teledermatology

Telemedicine allows for the evaluation of patients and management of initial and ongoing care while minimizing travel for veterans and clinical providers. The facility offers teleaudiology for patients located at a CBOC. During this process, the audiology health technician and the veteran located at the CBOC communicate with the audiologist at the facility through the use of teleconferencing equipment, cameras, and software to verify hearing aid performance and make needed adjustments. The facility

also offers teledermatology to CBOC patients and completed more than 1,300 dermatology consults in FY 2012.

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	Findings
	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.	
	Corrective actions from the protected peer review process were reported to the Peer Review Committee.	
	Focused Professional Practice Evaluations for newly hired licensed independent practitioners complied with selected requirements.	
X	Local policy for the use of observation beds complied with the selected requirements.	• The facility's policy did not include how the service or physician responsible for the patient is determined or that each observation patient must have a focused goal for the period of observation.
X	Data regarding appropriateness of observation bed use was gathered, and conversions to acute admissions were less than 30 percent.	• The facility did not gather observation bed use data.
	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.	
X	The cardiopulmonary resuscitation review policy and processes complied with requirements for reviews of episodes of care where resuscitation was attempted.	Twelve months of Critical Care Committee meeting minutes reviewed: • There was no evidence that the committee reviewed each cardiopulmonary resuscitation event. • There was no evidence that cardiopulmonary resuscitation event reviews included screening for clinical issues prior to the event.

NC	Areas Reviewed (continued)	Findings
	There was an EHR quality review committee, and the review process complied with selected requirements.	
	The EHR copy and paste function was monitored.	
X	Appropriate quality control processes were in place for non-VA care documents, and the documents were scanned into EHRs.	• The quality control policy for scanning did not include image quality, linking of scanned documents to the correct record, or indexing the documents. Nine EHRs of patients who had non-VA purchased diagnostic tests were reviewed: • Two test results were not scanned into the EHRs.
X	Use and review of blood/transfusions complied with selected requirements.	Four quarters of Transfusion Committee meeting minutes reviewed: • Meeting attendance did not include required members from surgery and medicine.
	CLC minimum data set forms were transmitted to the data center monthly.	
	Overall, if significant issues were identified, actions were taken and evaluated for effectiveness.	
	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 the local observation bed policy be revised to include all required elements.

2. We recommended that processes be strengthened to ensure that data about observation bed use is gathered.

3. We recommended that processes be strengthened to ensure that the Critical Care Committee reviews each cardiopulmonary resuscitation event and that cardiopulmonary resuscitation event reviews include screening for clinical issues prior to the event.

4. We recommended that the quality control policy for scanning be revised to include image quality, linking of scanned documents to the correct record, and indexing the documents.

5. We recommended that processes be strengthened to ensure that the results of non-VA purchased diagnostic tests are consistently scanned into EHRs.

6. We recommended that processes be strengthened to ensure that required members from surgery and medicine attend Transfusion Committee meetings.

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 ED; inpatient units (CLC, 6B medicine, 7A surgery, medical and surgical intensive care, and mental health); outpatient clinics (Primary Care Prime and 8A, women's health, and hematology/oncology); an occupational therapy and physical therapy outpatient treatment area in the CLC; the sleep laboratory; and the 4B short-stay unit. Additionally, we reviewed relevant documents and interviewed key employees and managers. 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 for General EOC	Findings
	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 problem 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.	
	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 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.	
	Fire safety requirements were met.	
	Environmental safety requirements were met.	
	Infection prevention requirements were met.	

NC	Areas Reviewed for the Women's Health Clinic (continued)	Findings
	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.	
	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.	

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 the CS Coordinator and 10 CS inspectors and inspection documentation from 10 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 25 employee training 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
X	A PCCT was in place and had the dedicated staff required.	List of staff assigned to the PCCT reviewed: • An administrative support person had not been dedicated to the PCCT.
	The PCCT actively sought patients appropriate for HPC.	
	The PCCT offered end-of-life training.	
	HPC staff and selected non-HPC staff 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 within 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

7. We recommended that processes be strengthened to ensure that the PCCT includes a dedicated administrative support person.

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 35 EHRs of patients enrolled in the home oxygen program (including 8 patients 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 VHA or 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 28 training files, and we interviewed key employees. Additionally, we reviewed the actual nursing hours per patient day for acute care unit 7B and CLC1A 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 35 EHRs of patients with confirmed diagnoses of pulmonary embolism[a] January 1–June 30, 2012. We also 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
X	Patients with potentially preventable pulmonary emboli received appropriate anticoagulation medication prior to the event.	• Two patients were identified as having potentially preventable pulmonary emboli because they had risk factors and had not been provided anticoagulation medication.
	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.	

Recommendation

8. We recommended that managers initiate protected peer review for the two identified patients and complete any recommended review actions.

[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.

Construction Safety

The purpose of this review was to determine whether the facility maintained infection control and safety precautions during construction and renovation activities in accordance with applicable standards.[8]

We inspected the ED and women's health construction projects. Additionally, we reviewed relevant documents and 20 training records (10 contractor and 10 employee), and we 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	Findings
	There was a multidisciplinary committee to oversee infection control and safety precautions during construction and renovation activities and a policy outlining the responsibilities of the committee, and the committee included all required members.	
	Infection control, preconstruction, interim life safety, and contractor tuberculosis risk assessments were conducted prior to project initiation.	
X	There is documentation of results of contractor tuberculosis skin testing and of follow-up on any positive results.	• Contractor tuberculosis skin test results were not documented for workers on the ED project.
	There was a policy addressing Interim Life Safety Measures, and required Interim Life Safety Measures were documented.	
	Site inspections were conducted by the multidisciplinary team members at least weekly and included all required elements.	
	Infection Control Committee minutes documented infection surveillance activities associated with the project(s) and any interventions.	
X	Construction Safety Committee minutes documented any unsafe conditions found during inspections and any follow-up actions and tracked actions to completion.	Construction Safety Committee minutes for the month of August reviewed: • Minutes did not contain documentation of deficiencies and follow-up actions in response to unsafe conditions identified during weekly ED inspections.
	Contractors and designated employees received required training.	
	Dust control requirements were met.	
	Fire and life safety requirements were met.	

NC	Areas Reviewed (continued)	Findings
X	Hazardous chemicals requirements were met.	• Material Data Safety Sheets for chemicals used by construction workers were not located within the construction areas.
	Storage and security requirements were met.	
	The facility complied with any additional elements required by VHA or local policy or other regulatory standards.	

Recommendations

9. We recommended that processes be strengthened to ensure that contractor tuberculosis skin test results for all projects are documented.

10. We recommended that processes be strengthened to ensure that Construction Safety Committee minutes contain documentation of deficiencies and follow-up actions in response to unsafe conditions identified during inspections.

11. We recommended that processes be strengthened to ensure that Material Safety Data Sheets for chemicals used in construction sites are located within the construction areas.

Facility Profile (Durham/558) FY 2012[b]	
Type of Organization	Tertiary
Complexity Level	1a-High complexity
Affiliated/Non-Affiliated	Affiliated
Total Medical Care Budget in Millions (through August 2012)	$445.8
Number of:	
• **Unique Patients**	59,084
• **Outpatient Visits**	552,785
• **Unique Employees**[c]	2,071
Type and Number of Operating Beds: (through August 2012)	
• **Hospital**	151
• **CLC**	120
• **Mental Health**	NA
Average Daily Census: (through August 2012)	
• **Hospital**	115
• **CLC**	67
• **Mental Health**	NA
Number of Community Based Outpatient Clinics	3
Location(s)/Station Number(s)	Greenville/558GA Raleigh/558GB Morehead City/ 558GC
VISN Number	6

[b] All data is for FY 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	62.8	60.5	52.8	45.8	50.4	43.1
VISN	62.5	59.5	51.8	48.8	49.7	49.7
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	17.3	12.6	11.4	20.1	24.4	15.4
U.S. National	15.5	11.6	12.0	19.7	24.7	18.5

[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 14, 2012

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

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

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

Director, Management Review Service (VHA 10AR MRS OIG CAP CBOC)

1. Attached is the action plan developed by the Durham VA Medical Center in response to the recommendations received during their recent OIG CAP review.

2. The Facility concurs with the findings and will ensure the corrective action plan is implemented.

3. If you have any 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 14, 2012

From: Director, Durham VA Medical Center (558/00)

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

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

1. Thank you for the opportunity to review the OIG report on the CAP Review of the Durham VA Medical Center. We concur with the recommendations, and will ensure completion as described in the implementation plan.

2. Please find attached our responses to each recommendation provided in the attached plan.

3. If you have any questions regarding the response to the recommendations, feel free to call me at (919) 416-8098.

(original signed by:)
DeAnne M. Seekins, MBA, VHA-CM

Comments to OIG's Report

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

OIG Recommendations

Recommendation 1. We recommended that the local observation bed policy be revised to include all required elements.

Concur

Target date for completion: January 31, 2013

Facility response: Our facility policy for the use of Observation status is being revised to include all the elements required by VHA Directive 2010-011. Our revised policy will include the missing elements of: 1) how the service or physician responsible for the patient is determined and 2) each observation patient must have a focused goal for the period of observation. The revised policy will be routed for approval through the Administrative Operations Committee on December 12 and will be published by January 31, 2013. Nursing and physician staff will receive training on the revision by February 28, 2013.

Recommendation 2. We recommended that processes be strengthened to ensure that data about observation bed use is gathered.

Concur

Target date for completion: November 26, 2012

Facility response: We have developed reporting tools and mechanisms for observation data. The data is being gathered by our Utilization Management (UM) staff and reported monthly to the Utilization Management Committee, which reports to the Executive Committee of the Medical Staff. The tool was developed by the VHA UM program office and forwarded to Durham VA UM staff on October 3, 2012. UM staff was trained on its use on October 16, 2012. The tool will be used starting with the November 26, 2012, UM Committee meeting.

Recommendation 3. We recommended that processes be strengthened to ensure that the Critical Care Committee reviews each cardiopulmonary resuscitation event and that cardiopulmonary resuscitation event reviews include screening for clinical issues prior to the event.

Concur

Target date for completion: December 11, 2012

Facility response: The Critical Care Committee (CCC) has revised the minute's structure to include a standing agenda item for the review of cardiopulmonary resuscitation events. A tool has been developed that aggregates data for all codes, the outcomes of each element reviewed, and numerical performance data measured for each code event. The spreadsheet graphs the performance and outcome data to facilitate trending and analysis of the data. The tool was approved at the November 13, 2012 CCC meeting. The Critical Care Nurse Educator was educated on the tool at the November meeting and it will be utilized for code data reporting beginning with the December 11, 2012, meeting. As of the December meeting, the minutes will include an analysis of the aggregated data for all the required review elements, which includes the screening for clinical issues prior to the event. Further, the committee minutes will clearly identify concerns with individual resuscitation episodes, discussion, and follow up. The Executive Committee of the Medical Staff (ECMS) has oversight of the Critical Care Committee and identified concerns from Critical Care will also be reflected in the ECMS minutes.

Recommendation 4. We recommended that the quality control policy for scanning be revised to include image quality, linking of scanned documents to the correct record, and indexing the documents.

Concur

Target date for completion: January 31, 2013

Facility response: MCM 136.13 will be revised to include the following elements: details for image quality, linking of scanned documents to the correct record, and indexing of documents. The policy revisions will clarify and define all aspects of the document scanning process including quality control procedures. The revised policy will be approved by Management of Information (MOI) Committee on January 20, 2013, and published by February 28, 2013. All staff responsible for scanning, including Non-VA Care Coordination staff, will receive education on the revisions to the policy by April 30, 2013.

Recommendation 5. We recommended that processes be strengthened to ensure that the results of non-VA purchased diagnostic tests are consistently scanned into EHRs.

Concur

Target date for completion: January 31, 2013

Facility response: Non-VA purchased care staff are currently scanning documents received by the Non-VA Care Coordination unit into Vista Imaging within 5 business days of receipt in accordance with a revised MCM 136.13. The revisions to MCM 136.13 clearly define the steps used to scan results of non-VA purchased diagnostic tests and to alert the requesting provider of the availability of the diagnostic test result. The revised MCM will be approved by Management of Information Committee on January 20, 2013, and published by February 28, 2013. All staff responsible for scanning, including Non-VA Care coordination staff, will received education on the

revisions to the policy by April 30, 2013. The auditing tool was approved by the Health Administration Service/Health Information Management Section Leadership and will be presented to the Medical Records Committee, December 19, 2012. Training on the new tool has begun for key staff and will be completed for all staff by April 30, 2013. The tool will measure the consistency and timeliness of the scanning process and the audit results will be reported to the Medical Records Committee with oversight by the Chief of HIMS or designee on a quarterly basis.

Recommendation 6. We recommended that processes be strengthened to ensure that required members from surgery and medicine attend Transfusion Committee meetings.

Concur

Target date for completion: November 7, 2012

Facility response: The Chair of the Transfusion Committee has worked with the Service Chiefs of Medicine and Surgery to assure coverage from each service so that in the event of an unanticipated absence or clinical need these services are still represented at committee meetings. Medicine and Surgery were represented at the November 7 meeting. The mandated attendance requirements of the Transfusion Committee will be overseen by ECMS.

Recommendation 7. We recommended that processes be strengthened to ensure that the PCCT includes a dedicated administrative support person.

Concur

Target date for completion: February 28, 2013

Facility response: The functional statement for the palliative care Social Worker is being revised to incorporate program leadership and data analysis to support quality improvement work for the palliative care program. The revised functional statement will be sent to the VISN 6 Social Work professional standards board for approval by December 21, 2012. The new program leadership and quality improvement functions for the Social Worker for palliative care will be implemented by February 28, 2013.

Recommendation 8. We recommended that managers initiate protected peer review for the two identified patients and complete any recommended review actions.

Concur

Target date for completion: November 27, 2012

Facility response: The peer reviews were initiated during the site visit. Both cases have been processed through our formal Protected Peer Review program and will be presented at the November 27, 2012, Peer Review Committee meeting with oversight provided by ECMS.

Recommendation 9. We recommended that processes be strengthened to ensure that contractor tuberculosis skin test results for all projects are documented.

Concur

Target date for completion: December 31, 2012

Facility response: As of October 1, 2012, all Durham construction contracts include the requirements for contractor TB testing prior to start of contract. This requirement is specified in SF 1442, Attachment to Solicitation, Offer and Award. A TB risk assessment was completed on October 23, 2012, for the existing construction contract, and based on that assessment, TB skin testing is not needed for the contract employees for this contract.

Recommendation 10. We recommended that processes be strengthened to ensure that Construction Safety Committee minutes contain documentation of deficiencies and follow-up actions in response to unsafe conditions identified during inspections.

Concur

Target date for completion: December 31, 2012

Facility response: The Construction Safety Committee minutes have been modified, as of November 29 2012, to include a tracking spreadsheet that lists all deficiencies. The deficiencies will be reviewed at each monthly meeting until the corrective action plan is complete. Oversight for the Construction Safety Committee is provided through Environment of Care Committee.

Recommendation 11. We recommended that processes be strengthened to ensure that Material Safety Data Sheets for chemicals used in construction sites are located within the construction areas.

Concur

Target date for completion: December 31, 2012

Facility response: The project specification general requirements section of VISN 6 contracting policy requires that all contractors submit and maintain a project-specific safety plan that includes Material Safety Data Sheets documentation for all hazardous chemicals that are on the job site. Additionally, the VISN 6 Preconstruction Conference Checklist includes a requirement for MSDS's for products and materials used on the project. MSDS's have been placed in readily accessible locations on the job site as of November 1, 2012.

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Endnotes

[1] References used for this topic included:
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- 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.
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- VHA Handbook 1100.19, *Credentialing and Privileging*, November 14, 2008.
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- 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.

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- 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:
- VHA Handbook 1108.01, *Controlled Substances (Pharmacy Stock)*, November 16, 2010.
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- VHA, "Clarification of Procedures for Reporting Controlled Substance Medication Loss as Found in VHA Handbook 1108.01," Information Letter 10-2011-004, April 12, 2011.
- VA Handbook 0730, *Security and Law Enforcement*, August 11, 2000.
- VA Handbook 0730/2, *Security and Law Enforcement*, May 27, 2010.

[4] References used for this topic included:
- VHA Directive 2008-066, *Palliative Care Consult Teams (PCCT)*, October 23, 2008.
- VHA Directive 2008-056, *VHA Consult Policy*, September 16, 2008.
- VHA Handbook 1004.02, *Advanced Care Planning and Management of Advance Directives*, July 2, 2009.
- VHA Handbook 1142.01, *Criteria and Standards for VA Community Living Centers (CLC)*, August 13, 2008.
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[5] References used for this topic were:
- VHA Directive 2006-021, *Reducing the Fire Hazard of Smoking When Oxygen Treatment is Expected*, May 1, 2006.
- VHA Handbook 1173.13, *Home Respiratory Care Program*, November 1, 2000.

[6] The references used for this topic were:
- VHA Directive 2010-034, *Staffing Methodology for VHA Nursing Personnel*, July 19, 2010.
- VHA "Staffing Methodology for Nursing Personnel," August 30, 2011.

[7] The reference used for this topic was:
- VHA Office of Analytics and Business Intelligence, *External Peer Review Technical Manual*, FY2012 quarter 4, June 15, 2012, p. 80–98.

[8] References used for this topic included:
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- VA Office of Construction and Facilities Management, *Master Construction Specifications*, Div. 1, "Special Sections," Div. 01 00 00, "General Requirements," Sec. 1.5, "Fire Safety."
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