Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 12-03744-84

Combined Assessment Program Review of the Central Texas Veterans Health Care System Temple, Texas

January 7, 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
CLC	community living center
CS	controlled substances
EHR	electronic health record
EOC	environment of care
facility	Central Texas Veterans Health Care System
FPPE	Focused Professional Practice Evaluation
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
QM	quality management
SPS	Sterile Processing Service
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 22, 2012.

Review Results: The review covered seven activities and one follow-up review area from the previous Combined Assessment Program review. We made no recommendations in the following activity:

- Nurse Staffing

The facility's reported accomplishment was the remodeled Sterile Processing Service. The facility took the lead in Veterans Integrated Service Network 17 by implementing the Event Ready Sterility Process and formalized the education and competency assessment program.

Recommendations: We made recommendations in the following six activities and the follow-up area from the previous Combined Assessment Program review:

Quality Management: Consistently report results of Focused Professional Practice Evaluations for newly hired licensed independent practitioners to the Medical Staff Executive Committee. Ensure the blood usage and review process includes the results of proficiency testing. Require that conversions from observation bed status to acute admissions are consistently 30 percent or less.

Environment of Care: Ensure that patient care areas are clean and well maintained, that clean and dirty supplies are stored separately, and that compliance is monitored. Require that damaged furniture in patient care areas and damaged therapy mats in the Temple division physical therapy clinic are repaired or removed from service and that the facility is well maintained.

Medication Management – Controlled Substances Inspections: Ensure that all required non-pharmacy areas with controlled substances are inspected and that compliance is monitored.

Coordination of Care – Hospice and Palliative Care: Ensure that the Palliative Care Consult Team includes a dedicated mental health provider and an administrative support person. Require that all hospice and palliative care staff and non-hospice and palliative care staff receive end-of-life training.

Long-Term Home Oxygen Therapy: Re-evaluate home oxygen program patients for home oxygen therapy annually after the first year.

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

Follow-Up on Environment of Care Rounds: Ensure that all required participants or their designees consistently attend environment of care rounds.

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 16–22, for the full text of the Directors' comments.) We consider recommendations 1, 2, and 8 closed. We will follow up on the planned actions for the open recommendations 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 seven activities and one follow-up review area from the previous CAP review:

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

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 22, 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 Central Texas Veterans Health Care System, Temple, Texas,* Report No. 10-01189-187, July 9, 2010). We made repeat recommendations in EOC.

During this review, we presented crime awareness briefings for 544 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 329 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

SPS

The facility underwent a reorganization, placing Environmental Management, SPS, Infection Prevention and Control, and Nutrition and Food Service along with Nursing Service under the Associate Director of Patient and Nursing Service. The collaboration among these services under the Associate Director of Patient and Nursing Service initiated the improvement in the sterilization and decontamination process for reusable medical equipment.

SPS responsibilities include providing the facility with all reprocessing needs for critical and semi-critical reusable medical equipment. The facility took the lead in VISN 17 by implementing the Event Ready Sterility Process. Channel checks are used on 100 percent of cleaned endoscopes to ensure an effective process of cleaning prior to disinfection or sterilization. Endoscope storage was centralized to enhance workflow. The facility also formalized the education and competency assessment program with the addition of an SPS educator and a targeted education plan. The partnership between SPS, Infection Prevention and Control, Perioperative Service, and the Associate Director for Patient Nursing Service has resulted in achieving SPS reusable medical equipment program goals and measurable outcomes to meet local and VISN expectations as well as Joint Commission standards and VHA requirements.

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.	
X	FPPEs for newly hired licensed independent practitioners complied with selected requirements.	Thirteen profiles reviewed: • None of the results of the 13 completed FPPEs were reported to the Medical Staff Executive Committee.
	Local policy for the use of observation beds complied with selected requirements.	
X	Data regarding appropriateness of observation bed use was gathered, and conversions to acute admissions were less than 30 percent.	Data for March–September 2012 reviewed: • Forty-three to 71 percent of observation patients were converted to acute admissions.
	Staff performed continuing stay reviews on 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.	
	There was an EHR quality review committee, and the review process complied with selected requirements.	
	The EHR copy and paste function was monitored.	

NC	Areas Reviewed (continued)	Findings
	Appropriate quality control processes were in place for non-VA care documents, and the documents were scanned into EHRs.	
X	Use and review of blood/transfusions complied with selected requirements.	Eight months of the Blood Usage Review Committee meeting minutes reviewed: • The review process did not include the results of proficiency testing.
	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 processes be strengthened to ensure that results of FPPEs for newly hired licensed independent practitioners are consistently reported to the Medical Staff Executive Committee.

2. We recommended that processes be strengthened to ensure that the blood usage and review process includes the results of proficiency testing.

3. We recommended that processes be strengthened to ensure that conversions from observation bed status to acute admissions are consistently 30 percent or less.

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]

At the Temple division, we inspected a medical, a surgical, and an intensive care unit and two CLC units; the emergency department; the women's health clinic; the wound care clinic; and two physical medicine and rehabilitation therapy clinics. At the Waco division, we inspected the psychiatric intensive care unit, an MH inpatient unit, and two CLC units; the women's health clinic; and two physical medicine and rehabilitation 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	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.	
X	Patient care areas were clean.	Three of the 17 units/areas inspected were not clean. This was a repeat finding from the previous CAP review. • Patient bathrooms on two MH inpatient units were dirty. • The wound care clinic was dirty.
	Fire safety requirements were met.	
X	Environmental safety requirements were met.	• We found damaged furniture in 5 of the 17 units/areas inspected. This was a repeat finding from the previous CAP review.
X	Infection prevention requirements were met.	• On 8 of the 17 units inspected, we found chipped paint on door trims where rust had formed and dirt had accumulated. This was a repeat finding from a previous CAP review. • The wound care clinic did not separate clean and dirty supplies.
	Medication safety and security requirements were met.	
	Sensitive patient information was protected, and patient privacy requirements were met.	

NC	Areas Reviewed for General EOC (continued)	Findings
	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.	
	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.	
X	Infection prevention requirements were met.	• Three therapy mats in the Temple division physical therapy clinic had torn surfaces.
	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 patient care areas are clean and well maintained and clean and dirty supplies are stored separately and that compliance be monitored.

5. We recommended that processes be strengthened to ensure that damaged furniture in patient care areas is repaired or removed from service and that the facility be well maintained.

6. We recommended that processes be strengthened to ensure that damaged therapy mats in the Temple division physical therapy clinic are repaired or removed from service.

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 10 CS areas, the inpatient and outpatient pharmacies, and the emergency drug cache. 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
	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.	
X	Non-pharmacy areas with CS were inspected in accordance with VHA requirements, and inspections included all required elements.	Documentation of all CS areas inspected during the past 6 months reviewed: • Three required areas were not inspected.
	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.	

Recommendation

7. We recommended that processes be strengthened to ensure that all required non-pharmacy areas with CS are inspected and that compliance be monitored.

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 (10 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 areas 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 MH provider and 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.	
X	HPC staff and selected non-HPC staff had end-of-life training.	• Of the 10 HPC staff, there was no evidence that 3 had end-of-life training. • Of the 15 non-HPC staff, there was no evidence that 11 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.	

NC	Areas Reviewed (continued)	Findings
	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.	

Recommendations

8. We recommended that processes be strengthened to ensure that the PCCT includes a dedicated MH provider and an administrative support person.

9. We recommended that processes be strengthened to ensure that all HPC staff and 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 34 EHRs of patients enrolled in the home oxygen program (including 9 patients deemed to be high risk), 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
	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.	
X	Home oxygen program patients had active orders/prescriptions for home oxygen and were re-evaluated for home oxygen therapy annually after the first year.	• Of the 31 patients in the program longer than 12 months, there was no documentation that 11 (35 percent) were re-evaluated 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.	

Recommendation

10. We recommended that processes be strengthened to ensure that home oxygen program patients are re-evaluated for home oxygen therapy annually after the first year.

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 29 training files, and we interviewed key employees. Additionally, we reviewed the actual nursing hours per patient day for acute care unit 2K and CLC unit 6J 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 40 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 areas 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.
X	No additional quality of care issues were identified with the patients' care.	• One patient was identified as having a delayed diagnosis of a deep venous thrombosis.
	The facility complied with any additional elements required by VHA or local policy/protocols.	

Recommendation

11. We recommended that managers initiate a protected peer review for the three 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.

Review Activity with Previous CAP Recommendations

Follow-Up on EOC Rounds

As a follow-up to a recommendation from our prior CAP review, we reassessed facility compliance with EOC rounds attendance.

EOC Rounds. VHA requires that the Director or Associate Director lead weekly EOC rounds.[8] Managers in nursing, building management, engineering, safety, patient safety, and infection control must be included as well as the Information Security Officer and others, as required. We reviewed EOC rounds documentation and determined that all required participants or their designees did not consistently participate in EOC rounds.

Recommendation

12. We recommended that processes be strengthened to ensure that all required participants or their designees consistently attend EOC rounds.

Facility Profile (Temple/674) FY 2012[b]	
Type of Organization	Secondary
Complexity Level	1c-High complexity
Affiliated/Non-Affiliated	Affiliated
Total Medical Care Budget in Millions (through August 2012)	$580.7
Number of:	
• **Unique Patients**	91,423
• **Outpatient Visits**	1,071,586
• **Unique Employees**[c]	2,664
Type and Number of Operating Beds:	
• **Hospital (through August 2012)**	189
• **CLC (through August 2012)**	230
• **MH**	470
Average Daily Census:	
• **Hospital**	113
• **CLC**	148
• **MH**	278
Number of Community Based Outpatient Clinics	4
Location(s)/Station Number(s)	Brownwood/674GB Bryan/College Station/674GC Cedar Park/674GD Palestine/674GA
VISN Number	17

[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 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	65.4	70.9	48.2	42.7	51.3	57.9
VISN	60.7	57.9	40.5	47.5	48.5	48.7
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	15.6	10.5	11.9	22.9	25.3	17.5
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: December 13, 2012

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

Subject: **CAP Review of the Central Texas Veterans Health Care System, Temple, TX**

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

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

1. Thank you for allowing me to respond to this CAP Review of the Central Texas Veterans Health Care System, Temple, TX.

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

3. If you have further questions regarding this CAP review, please contact Denise B. Elliott, VISN 17 Health Systems Specialist at 817-385-3734.

Lawrence A. Biro
Director, VA Heart of Texas Health Care Network (10N17)

Facility Director Comments

Department of Veterans Affairs **Memorandum**

Date: December 11, 2012

From: Director, Central Texas Veterans Health Care System (674/00)

Subject: **CAP Review of the Central Texas Veterans Health Care System, Temple, TX**

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

1. I would like to express our sincere appreciation to the Office of the Inspector General (OIG) Combined Assessment Program (CAP) review team for their professionalism, consultative approach, and feedback provided during the review conducted on October 22–25, 2012.

2. The recommendations were reviewed and our concurrence is delineated below. Corrective action plans have been developed and executed for continuous monitoring. CTVHCS welcomes the external perspective provided, which we will use to further strengthen the quality of care provided to our Veterans.

3. Should you have questions or require additional information, please do not hesitate to contact Sylvia Tennent, Chief Quality Management and Improvement Service at extension 254-743-0719.

(original signed by:)
Thomas C. Smith, FACHE
Director, Central Texas Veterans Health Care System (674/00)

Comments to OIG's Report

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

OIG Recommendations

Recommendation 1. We recommended that processes be strengthened to ensure that results of FPPEs for newly hired licensed independent practitioners are consistently reported to the Medical Staff Executive Committee.

Concur

Target date for completion: Completed November 20, 2012

Facility response: The reporting of 90-day Focused Professional Practice Evaluations (FPPE) was initiated on October 23, 2012, and report submitted to the Medical Staff Executive Council (MSEC) on November 20, 2012. The recurring FPPE monthly report is now included with the other existing reports submitted to both the Medical Staff Practice Standards Board (MSPSB) and the MSEC.

Recommendation 2. We recommended that processes be strengthened to ensure that the blood usage and review process includes the results of proficiency testing.

Concur

Target date for completion: Completed December 7, 2012

Facility response: Following the OIG CAP review, the Transfusion Utilization Committee (TUC) was initiated. Blood utilization review reports including proficiency testing began on December 7, 2012. In addition, reports are submitted to the Medical Staff Executive Council, the oversight council.

Recommendation 3. We recommended that processes be strengthened to ensure that conversions from observation bed status to acute admissions are consistently 30 percent or less.

Concur

Target date for completion: February 28, 2013

Facility response: An interdisciplinary process improvement team was convened on November 30, 2012, to review the current observation/admission conversion process. The team is charged to provide a recommendation within 90 days, which will be reviewed and presented to the Medical Staff Executive Council (MSEC). Monthly monitoring and reporting will be conducted to ensure conversion rates are consistently

30 percent or less and submitted to the Patient Flow/Throughput Committee and the MSEC.

Recommendation 4. We recommended that processes be strengthened to ensure that patient care areas are clean and well maintained and clean and dirty supplies are stored separately and that compliance be monitored.

Concur

Target date for completion: Ongoing

Facility response: The process has been strengthened to ensure patient care areas are clean and maintained. A) The Chief Environmental Management Services (EMS) has worked with Nursing Service to ensure access to these areas and has designed a cleaning schedule to incorporate these areas for daily cleaning. The cleaning was completed on November 7, 2012. Monthly monitoring will be conducted and reports will be submitted to the Infection Control Committee and the Nursing Executive Council starting December 13, 2012.

B) Wound Care Clinic: A team approach was leveraged to review the current process at the clinic. Relevant changes were executed including the re-education of the Nurse Practitioner (NP) regarding organizing and separation of clean, sterile, and other supplies. A strategy for monitoring weekly and monthly by Infection Control and Sterile Processing Service (SPS) has been executed to ensure compliance and sustainability. Monthly tracers will also be conducted starting December 13, 2012. Outcomes will be reported to the Infection Control Committee and the Medical Staff Executive Council starting December 13, 2012.

Recommendation 5. We recommended that processes be strengthened to ensure that damaged furniture in patient care areas is repaired or removed from service and that the facility be well maintained.

Concur

Target date for completion: December 30, 2012

Facility response: The process has been strengthened and staff in the affected areas will enter work orders as these issues are identified and Engineering will complete these work orders by December 30, 2012. Monthly Oversight monitoring will be conducted and reported to the Environment of Care Executive Committee and Executive Leadership Board. In addition, these areas will be reviewed during Environment of Care Rounds.

Recommendation 6. We recommended that processes be strengthened to ensure that damaged therapy mats in the Temple division physical therapy clinic are repaired or removed from service.

Concur

Target date for completion: December 17, 2012.

Facility response: Requests were submitted for repair of two of the three mats at the time of the OIG CAP survey. A written request for repair of the Occupational Therapy mat was sent to the Interior Designer on October 23, 2012. Cost estimates were conducted and the projected completion date is December 17, 2012. The Physical Medicine and Rehabilitation staff have been educated to immediately report the need for repairs. Monthly Environment of Care rounds are conducted to identify the need for repairs that have not been reported. Unresolved issues are addressed in the monthly PM&RS CQI Committee. The reporting will also include the Infection Control Committee and the Nursing Executive Council starting December 2012.

Recommendation 7. We recommended that processes be strengthened to ensure that all required non-pharmacy areas with CS are inspected and that compliance be monitored.

Concur

Target date for completion: April 30, 2013

Facility response: The process has been strengthened by ensuring that all inspections are assigned to inspectors to be accomplished within the first 3 weeks of the month. Inspections not completed within the required timeline are completed by the Controlled Substances Inspections site manager. Inspections not completed by the last business day of the month will be completed by the Controlled Substances Inspections Coordinator (CSIC). Monthly aggregated reports will be reported to the Director and discrepancies will be reported to the Pharmacy and Therapeutics Committee (P&T), starting January 2013.

Recommendation 8. We recommended that processes be strengthened to ensure that the PCCT includes a dedicated MH provider and an administrative support person.

Concur

Target date for completion: Completed December 3, 2012

Facility response: Psychology Service is actively recruiting for a Mental Health provider to support the Palliative Care Consult Team (PCCT) a minimum of 0.25 FTE. The provider is expected to be on board by March 31, 2013. During the interim, a Mental Health provider was assigned to the PCCT on November 28, 2012. The GEC Administrative Support Assistant was assigned to support the PCCT 0.25 FTE on December 3, 2012.

Recommendation 9. We recommended that processes be strengthened to ensure that all HPC staff and non-HPC staff receive end-of-life training.

Concur

Target date for completion: April 30, 2013

Facility response: The Acting Chief, GEC and Hospice Physician are developing the End-of-Life Training course of which will be available in the Talent Management System (TMS) for easy access and to facilitate tracking. Request to be submitted to Medical Staff Executive Council (MSEC) for approval to mandate Hospice & Palliative Care training for all staff both palliative and non-palliative care system-wide. Monitoring will be conducted monthly with aggregated reports submitted to the Geriatrics Extended Care Committee (GEC) and the Medical Staff Executive Council (MSEC), starting April 30, 2013. In addition, End-of-Life Education Consortium is currently offered annually, and the Palliative Care Consult Team (PCCT) staff is also developing a curriculum specifically targeted for staff in the identified areas with proposed implementation by January 30, 2013.

Recommendation 10. We recommended that processes be strengthened to ensure that home oxygen program patients are re-evaluated for home oxygen therapy annually after the first year.

Concur

Target date for completion: Ongoing

Facility response: The policy for Home Respiratory Care Team (HRCT) was revised to align with the VHA Directive 2006-21, and incorporate the language regarding requiring all patients on home oxygen receive re-evaluation annually, at a minimum. The policy was presented and approved by the Medical Staff Executive Council on November 16, 2012. The aggregated data for October 2012 was submitted to the MSEC on December 4, 2012, and future reports will continue monthly. A process was designed to ensure all prescriptions are renewed prior to expiration by a provider or leverage an administrative renewal. The Prosthetic's home oxygen expired prescription is monitored and reported to the Home Respiratory Care Team quarterly, together with monthly reports to the MSEC. In addition, members of the HRCT were educated regarding the policy changes on November 6, 2012.

Recommendation 11. We recommended that managers initiate a protected peer review for the three identified patients and complete any recommended review actions.

Concur

Target date for completion: January 22, 2013

Facility response: The Risk Manager initiated the peer review process for the three identified cases on October 25th, 29th, and November 1st, 2012. The reviews are due

to the Risk Manager on December 4th, 8th, and 11th, 2012, which will be reviewed at the January 22, 2013, Peer Review Committee in accordance with the assigned levels.

Recommendation 12. We recommended that processes be strengthened to ensure that all required participants or their designees consistently attend EOC rounds.

Concur

Target date for completion: February 28, 2013

Facility response: A weekly tracking spreadsheet has been created and was sent to senior leadership for action by the appropriate manager. Additionally, a local policy is in the development process to clarify the Environment of Care (EOC) Team member roles and requirements for attendance. This policy will be coordinated and reviewed by the Environment of Care Executive Committee (EOCC) and submitted to the Executive Leadership Board (ELB) for approval by February 28, 2013.

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Endnotes

[1] References used for this topic included:
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[3] References used for this topic included:
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[6] The references used for this topic were:
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[7] The reference used for this topic was:
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[8] The reference used for this review area was:

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