Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 12-04189-95

Combined Assessment Program Review of the Oklahoma City VA Medical Center Oklahoma City, Oklahoma

January 28, 2013

Washington, DC 20420

To Report Suspected Wrongdoing in VA Programs and Operations
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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	Oklahoma City VA Medical Center
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
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Table of Contents

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 November 5, 2012.

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

- Quality Management
- Environment of Care
- Coordination of Care – Hospice and Palliative Care
- Nurse Staffing

The facility's reported accomplishment was the implementation of interventions to reduce central line infections. As a result of these interventions, there were no central line infections in the intensive care unit or non-intensive care units for June through August 2012.

Recommendations: We made recommendations in the following three activities:

Medication Management – Controlled Substances Inspections: Initiate actions to address the three identified deficiencies, and ensure all deficiencies identified during annual physical security surveys are corrected. Conduct monthly inspections of automatic dispensing machines in accordance with local policy. Consistently provide monthly controlled substances inspection findings summaries and quarterly trend reports to the facility Director. Include Controlled Substance Coordinator duties in the position description. Inspect all required non-pharmacy areas with controlled substances monthly, and monitor compliance. Conduct monthly inspections of all pharmacy areas with controlled substances, and monitor compliance.

Long-Term Home Oxygen Therapy: Ensure the Chief of Staff reviews Home Respiratory Care Program activities at least quarterly. Re-evaluate home oxygen program patients for home oxygen therapy annually after the first year.

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

Comments

The Veterans Integrated Service Network Director and Acting Facility Director 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 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:

- 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 2011, FY 2012, and FY 2013 through November 5, 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 Oklahoma City VA Medical Center, Oklahoma City, Oklahoma,* Report No. 11-00031-197, June 10, 2011).

During this review, we presented crime awareness briefings for 234 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 240 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

Interventions to Reduce Central Line Infections

In February 2012, the facility's infection control department developed an action plan aimed at reducing central line infections. A retrospective review of central line associated bloodstream infections identified in FY 2011 and FY 2012 was conducted to seek previously unrecognized risk factors associated with circumstances, sites of placement, and daily maintenance.

The infection control department established a central line associated bloodstream team to discuss central line issues and recommendations for corrections. A central line bundle (infection prevention practices for patient safety) daily check sheet for each patient was developed, and the team recommended use of the subclavian vein as the insertion site instead of the femoral or internal jugular veins. As a result of these interventions, there were no central line infections in the intensive care unit or non-intensive care unit units from June through August 2012, which exceeded the VISN goal.

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. 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 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.	
	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.	
	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.	
	Use and review of blood/transfusions complied with selected requirements.	
	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.	

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 surgical, neurology, CLC, surgical intensive care, and locked MH units; two medical units; the women's health clinic; the emergency department; and the physical and occupational therapy clinics. 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.	
	Medication safety and security requirements were met.	

NC	Areas Reviewed for the Women's Health Clinic (continued)	Findings
	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 pharmacy areas, 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.	
X	VA police conducted annual physical security surveys of the pharmacy/pharmacies, and any identified deficiencies were corrected.	Annual physical security surveys for past 2 years reviewed: • Three identified deficiencies had not been corrected, and managers did not have action plans or an explanation for why the items remained unresolved.
X	Instructions for inspecting automated dispensing machines were documented, included all required elements, and were followed.	Automated dispensing machine inspection instructions and inspection documentation reviewed: • Inspections of all automated dispensing machines were not conducted each month or in accordance with local policy.
X	Monthly CS inspection findings summaries and quarterly trend reports were provided to the facility Director.	Summary of CS inspection findings for the past 6 months and quarterly trend reports for the past 4 quarters reviewed: • Five monthly findings summaries were not provided to the facility Director. • Three quarterly trend reports were not provided to the facility Director.
X	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.	Position description and certification reviewed: • The CS Coordinator's position description did not include coordinator duties.
	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: • Five monthly inspections were not conducted.
X	Pharmacy CS inspections were conducted in accordance with VHA requirements and included all required elements.	Documentation of pharmacy CS inspections during the past 6 months reviewed: • Three monthly inspections were not conducted.

NC	Areas Reviewed (continued)	Findings
	The facility complied with any additional elements required by VHA or local policy.	

Recommendations

1. We recommended that managers initiate actions to address the three identified deficiencies and that processes be strengthened to ensure that all deficiencies identified during annual physical security surveys are corrected.

2. We recommended that processes be strengthened to ensure that monthly inspections of automatic dispensing machines are conducted in accordance with local policy.

3. We recommended that processes be strengthened to ensure that monthly CS inspection findings summaries and quarterly trend reports are consistently provided to the facility Director.

4. We recommended that the CS Coordinator's duties be included in the position description.

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

6. We recommended that processes be strengthened to ensure that monthly inspections of all pharmacy areas with CS are conducted 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. Items that did not apply to this facility are marked "NA." The facility generally met requirements. We made no recommendations.

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.	
	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 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.	

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 11 patients deemed to be high risk), 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
	There was a local policy to reduce the fire hazards of smoking associated with oxygen treatment.	
X	The Chief of Staff reviewed Home Respiratory Care Program activities at least quarterly.	• We found no evidence that program activities were reviewed 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.	• Ten EHRs (29 percent) contained no documentation of a re-evaluation 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.	

Recommendations

7. We recommended that processes be strengthened to ensure that the Chief of Staff reviews Home Respiratory Care Program activities at least quarterly.

8. 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 54 training files, and we interviewed key employees. Additionally, we reviewed the actual nursing hours per patient day for acute care unit 6N and the long-term care CLC unit 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 34 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.
	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

9. 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.

Facility Profile (Oklahoma City/635) FY 2012[b]	
Type of Organization	Tertiary
Complexity Level	1b-High complexity
Affiliated/Non-Affiliated	Affiliated
Total Medical Care Budget in Millions (through August 2012)	$398.4
Number of:	
• **Unique Patients**	56,161
• **Outpatient Visits**	522,902
• **Unique Employees[c] (as of last pay period in FY 2012)**	1,622
Type and Number of Operating Beds:	
• **Hospital**	139
• **CLC**	33
• **MH**	Not reported
Average Daily Census: (through August 2012)	
• **Hospital**	115
• **CLC**	24
• **MH**	Not reported
Number of Community Based Outpatient Clinics	8
Location(s)/Station Number(s)	Ardmore/635HB Altus/635GF Enid/635GG Blackwell/635GC Lawton/635GA Stillwater/635GE Wichita Falls/635GB Ada/635GD
VISN Number	16

[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 satisfaction scores for quarters 3–4 of FY 2011 and quarters 1–2 of FY 2012 and outpatient satisfaction scores for quarter 4 of FY 2011 and quarters 1–3 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 4	Outpatient Score Quarter 1	Outpatient Score Quarter 2	Outpatient Score Quarter 3
Facility	55.0	61.2	46.1	43.4	46.9	41.3
VISN	65.9	64.1	50.7	52.3	50.9	50.6
VHA	64.1	63.9	54.5	55.0	54.7	54.3

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	12.5	13.5	18.5	26.5	22.4
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: January 4, 2013

From: Director, South Central VA Health Care Network (10N16)

Subject: **CAP Review of the Oklahoma City VA Medical Center, Oklahoma City, OK**

To: Director, San Diego Office of Healthcare Inspections (54SD)

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

1. The South Central VA Health Care Network (VISN 16) has reviewed the response from the Oklahoma City VA Medical Center and concurs with the response.

2. If you have any questions, please contact Adrienne Riesenbeck, Director, Office of Performance and Quality, at (405) 456-3146.

Rica Lewis-Payton, MHA, FACHE
Network Director

Acting Facility Director Comments

Department of Veterans Affairs **Memorandum**

Date: January 2, 2013

From: Acting Director, Oklahoma City VA Medical Center (635/00)

Subject: **CAP Review of the Oklahoma City VA Medical Center, Oklahoma City, OK**

To: Director, South Central VA Health Care Network (10N16)

1. We appreciate the opportunity to work with the Office of Inspector General as we continuously strive to improve the quality of healthcare for America's Veterans.

2. I concur with the findings and recommendations of the OIG CAP Survey Team. The importance of this review is acknowledged as we continually strive to provide the best possible care.

3. If you have any questions, please contact Adrienne Riesenbeck, Director, Office of Performance and Quality, at (405) 456-3146.

Francisco Vazquez, M.B.A.
Acting Director

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 managers initiate actions to address the three identified deficiencies and that processes be strengthened to ensure that all deficiencies identified during annual physical security surveys are corrected.

Concur

Target date for completion: Complete

Facility response: On December 12, 2012 a follow up physical security inspection was completed, no deficiencies were found during this inspection. Beginning December 2012, results from the physical security inspections are reported to the Environment of Care Committee where deficiencies are tracked to closure. This will be a standing agenda item in the Environment of Care Committee.

Recommendation 2. We recommended that processes be strengthened to ensure that monthly inspections of automatic dispensing machines are conducted in accordance with local policy.

Concur

Target date for completion: Complete

Facility response: Beginning September 2012, the duties of the Controlled Substance Coordinator were transitioned to the Office of Performance and Quality to enhance oversight of this program. As an additional measure, compliance with the requirements was added to the Medical Staff Executive Committee (SPICE) reporting grid to be reported quarterly, beginning October 2012, to improve oversight of the program requirements. For September thru December 2012, 100% of controlled substance inspections were completed.

Recommendation 3. We recommended that processes be strengthened to ensure that monthly CS inspection findings summaries and quarterly trend reports are consistently provided to the facility Director.

Concur

Target date for completion: Complete

Facility response: The Controlled Substance Coordinator has a standing monthly meeting with the Facility Director beginning October 2012. As an additional measure,

any discrepancies or concerns identified by the Controlled Substance Coordinator are immediately communicated to the facility director. Beginning September 2012, monthly summary reports have been provided to the facility director. Beginning in January 2013 quarterly trending reports will be provided to the facility director.

Recommendation 4. We recommended that the CS Coordinator's duties be included in the position description.

Concur

Target date for completion: Complete

Facility response: The Controlled Substance Coordinator's position description was revised to include the controlled substance inspection duties. The position description was approved on August 22, 2012.

Recommendation 5. We recommended that processes be strengthened to ensure that all required non-pharmacy areas with CS are inspected monthly and that compliance be monitored.

Concur

Target date for completion: Complete

Facility response: Beginning September 2012, the duties of the Controlled Substance Coordinator were transitioned to the Office of Performance and Quality to enhance oversight of this program. As an additional measure, compliance with the requirements was added to the Medical Staff Executive Committee (SPICE) reporting grid to be reported quarterly, beginning October 2012, to improve oversight of the program requirements. For September thru December 2012, 100% of controlled substance inspections were complete.

Recommendation 6. We recommended that processes be strengthened to ensure that monthly inspections of all pharmacy areas with CS are conducted and that compliance be monitored.

Concur

Target date for completion: Complete

Facility response: Beginning September 2012, the duties of the Controlled Substance Coordinator were transitioned to the Office of Performance and Quality to enhance oversight of this program. As an additional measure, compliance with the requirements was added to the Medical Staff Executive Committee (SPICE) reporting grid to be reported quarterly, beginning October 2012, to improve oversight of the program requirements. For September thru December 2012, 100% of controlled substance inspections were complete.

Recommendation 7. We recommended that processes be strengthened to ensure that the Chief of Staff reviews Home Respiratory Care Program activities at least quarterly.

Concur

Target date for completion: Complete

Facility response: The Home Respiratory Care Committee started reporting to the Medical Staff Executive Committee (SPICE) in November 2012. The Chief of Staff is the Committee Chair of the Medical Staff Executive Committee. The Home Respiratory Care Committee will continue to report quarterly.

Recommendation 8. 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: Complete

Facility response: Education on the provider's role in completing annual re-evaluations for patients receiving home oxygen therapy was completed on November 14, 2012. The Home Respiratory Care Coordinator verifies that the provider completed a re-evaluation prior to renewing home oxygen therapy. The Home Respiratory Care Coordinator is developing a spreadsheet to track the date of the provider re-evaluations to ensure that re-evaluations are completed prior to renewing home oxygen therapy. For December 2012, we are 93% compliant.

Recommendation 9. We recommended that managers initiate protected peer review for the two identified patients and complete any recommended review actions.

Concur

Target date for completion: Complete

Facility response: Peer reviews for the two identified patients were completed and presented to the Peer Review Committee on November 29, 2012. The peer reviews were both assigned a level 1 with no further recommendations from the committee members. The Peer Reviews were uploaded to a secure SharePoint for the OIG to review on December 3, 2012.

OIG Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the OIG at (202) 461-4720.
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U.S. House of Representatives: Tom Cole, James Lankford, Frank Lucas

This report is available at http://www.va.gov/oig.

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*, September 19, 2012.
- 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:
- VHA Handbook 1108.01, *Controlled Substances (Pharmacy Stock)*, November 16, 2010.
- VHA Handbook 1108.02, *Inspection of Controlled Substances*, March 31, 2010.
- VHA Handbook 1108.05, *Outpatient Pharmacy Services*, May 30, 2006.
- VHA Handbook 1108.06, *Inpatient Pharmacy Services*, June 27, 2006.
- 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.
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