Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 12-04190-89

Combined Assessment Program Review of the North Florida/South Georgia Veterans Health System Gainesville, Florida

January 17, 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	North Florida/South Georgia Veterans Health System
FPPE	Focused Professional Practice Evaluation
FY	fiscal year
HPC	hospice and palliative care
NA	not applicable
NC	noncompliant
OIG	Office of Inspector General
PACS	Picture Archiving and Communication System
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 November 5, 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 three activities:

- Environment of Care
- Medication Management – Controlled Substances Inspections
- Nurse Staffing

The facility's reported accomplishments were hospice and palliative care staff education and imaging advances.

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

Quality Management: Ensure that Focused Professional Practice Evaluations for newly hired licensed independent practitioners are consistently initiated and that results are reported to the Medical Executive Committee. Revise the local observation bed policy to include all required elements, and gather data about observation bed use. Perform continuing stay reviews for at least 75 percent of acute care patients. Ensure that individual resuscitation events are reviewed and that the review of electronic health record quality includes all services. Require that the blood usage review process includes the results of proficiency testing done by the laboratory.

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

Long-Term Home Oxygen Therapy: Ensure the Chief of Staff reviews Home Respiratory Care Program activities at least quarterly.

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

Follow-Up on Environment of Care Issue: Ensure all designated staff complete respirator fit testing.

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 17–21, 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 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 Issue

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 North Florida/South Georgia Veterans Health System,*

Gainesville, Florida, Report No. 10-00054-218, August 10, 2010). We made a repeat recommendation in EOC.

During this review, we presented crime awareness briefings for 442 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 736 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

HPC Education

The facility provides end-of-life education programs in collaboration with community partners throughout the North Florida area. In 2011 and 2012, 212 VA staff and 165 community partners participated in the End-of-Life Nursing Education Consortium course. In addition, Nursing Education Service provided HPC training for 285 nursing assistants who provide direct care to veterans at the facility.

Imaging Advances

The facility obtained a 320-slice computed tomography scanner in November 2011. There are less than 90 such scanners installed at hospitals across the country. The scanner provides high-quality three-dimensional images of the pulsing heart and other organs in less than 2 minutes. The ability to image an entire functioning organ leads to faster, more accurate diagnoses; better patient outcomes; and lower health care costs.

In addition, VISN 8 is one of only two VISNs and one of only a few private hospital systems in the country to have a multi-hospital PACS. PACS is a digital system that enables radiologists in different locations to analyze and discuss images from any hospital in VISN 8 from their local workstation. PACS is also directly linked into the patient EHR, so images and results can be accessed by providers from anywhere in VISN 8. With this system, there are faster turnaround times, improved patient safety, and lower costs.

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.	Twenty-eight profiles reviewed: • Six FPPEs were not initiated. • None of the results of the 22 completed FPPEs were reported to Medical Executive Committee.
X	Local policy for the use of observation beds complied with selected requirements.	• The facility's policy did not include that each observation patient must have a focused goal for the period of observation and a clear delineation of the service and physician responsible for the care provided.
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.
X	Staff performed continuing stay reviews of at least 75 percent of patients in acute beds.	Data for April–June 2012 reviewed: • Staff performed continuing stay reviews for less than 75 percent of acute care patients.
	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.	Six months of Emergency Effectiveness Committee meeting minutes reviewed: • There was no evidence that the committee reviewed individual resuscitation events.

NC	Areas Reviewed (continued)	Findings
X	There was an EHR quality review committee, and the review process complied with selected requirements.	Six months of EHR Committee meeting minutes reviewed: • Not all services were included in reviews of EHR quality.
	The EHR copy and paste function was monitored.	
	Appropriate quality control processes were in place for non-VA care documents, and the documents were scanned into EHRs.	
X	Use and review of blood/transfusions complied with selected requirements.	Three quarters of Transfusion Utilization Committee meeting minutes reviewed: • The minutes did not include the results of proficiency testing completed by the laboratory.
	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 FPPEs for newly hired licensed independent practitioners are consistently initiated and that results are reported to the Medical Executive Committee.

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

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

4. We recommended that processes be strengthened to ensure that staff perform continuing stay reviews for at least 75 percent of acute care patients.

5. We recommended that processes be strengthened to ensure that the Emergency Effectiveness Committee reviews individual resuscitation events.

6. We recommended that processes be strengthened to ensure that the review of EHR quality includes all services.

7. We recommended that processes be strengthened to ensure that the blood usage review process includes the results of proficiency testing done by the laboratory.

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 Gainesville campus, we inspected the emergency department and the physical therapy, occupational therapy, chemotherapy, and women's health clinics. We also inspected the medical, medical/surgical/step-down, surgical intensive care, dialysis, CLC, and locked mental health units. At the Lake City campus, we inspected the emergency department; the physical therapy, occupational therapy, and women's health clinics; and the medical/surgical intensive care, the hospice, two medical, and three CLC units. 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.	

NC	Areas Reviewed for the Women's Health Clinic (continued)	Findings
	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.	
	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 all CS Coordinators and 10 CS inspectors and inspection documentation from 31 sections of 8 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	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.	
	Non-pharmacy areas with CS were inspected in accordance with VHA requirements, and inspections included all required elements.	
	Pharmacy CS inspections were conducted in accordance with VHA requirements and included all required elements.	
	The facility complied with any additional elements required by VHA or local policy.	

Coordination of Care – HPC

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

We reviewed relevant documents, 20 EHRs of patients who had PCCT consults (including 10 HPC inpatients), and 23 employee training records (8 HPC staff and 15 non-HPC staff), 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: • A nurse 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.	
	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.	

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

Recommendation

8. We recommended processes be strengthened to ensure that the PCCT includes a dedicated nurse and 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 5 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.	
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.	
	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.	

Recommendation

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

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 4W at the Gainesville campus and CLC unit 4 at the Lake City campus 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 68 EHRs of patients with 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 but may not have received appropriate care.
	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

10. 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.

Review Activity with Previous CAP Recommendations

Follow-Up on EOC Issue

As a follow-up to a recommendation from our prior CAP review, we reassessed facility compliance with respirator fit testing.

Respirator Fit Testing. VHA requires facilities using N95 and other types of respirators to fit test designated staff annually.[8] The respirator fit testing compliance rate for all designated employees at the Gainesville campus for FY 2012 was 71 percent.

Recommendation

11. We recommended that processes be strengthened to ensure that all designated staff complete respirator fit testing.

Facility Profile (Gainesville/573) FY 2012[b]	
Type of Organization	Tertiary
Complexity Level	1a-High complexity
Affiliated/Non-Affiliated	Affiliated
Total Medical Care Budget in Millions	$822.8
Number of:	
• **Unique Patients**	123,157
• **Outpatient Visits**	1,384,744
• **Unique Employees**[c]	3,636
Type and Number of Operating Beds:	
• **Hospital**	277
• **CLC**	264
• **Mental Health**	74
Average Daily Census: (through August 2012)	
• **Hospital**	207
• **CLC**	162
• **Mental Health**	68
Number of Community Based Outpatient Clinics	7
Location(s)/Station Number(s)	Lecanto, FL/573GG Marianna, FL/573GK Ocala, FL/573GD Palatka, FL/573GL St. Augustine, FL/573GE St. Marys, GA/573GJ Valdosta, GA/573GA
VISN Number	8

[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	60.6	69.5	56.7	60.6	55.9	53.9
VISN	63.7	67.9	58.8	59.4	56.5	55.4
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	18.7	11.9	9.6	21.0	24.2	21.0
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 20, 2012

From: Director, VA Sunshine Healthcare Network (10N8)

Subject: **CAP Review of the North Florida/South Georgia Veterans Health System, Gainesville, FL**

To: Associate Director, Bay Pines Office of Healthcare Inspections (54SP)

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

1. I have reviewed the findings and concur with the recommendations in the report of the Combined Assessment Program Review of the North Florida/South Georgia Veterans Health System, Gainesville, Florida.

2. Corrective action plans have been established with planned completion dates, as detailed in the attached report.

Thank you,

Nevin M. Weaver

Nevin M. Weaver, FACHE
Director, VA Sunshine Healthcare Network (10N8)

Facility Director Comments

Department of Veterans Affairs **Memorandum**

Date: December 14, 2012

From: Director, North Florida/South Georgia Veterans Health System (573/00)

Subject: **CAP Review of the North Florida/South Georgia Veterans Health System, Gainesville, FL**

To: Director, VA Sunshine Healthcare Network (10N8)

1. I have reviewed and concur with the findings and recommendations in the report of the Combined Assessment Program Review.

2. Corrective action plans have been established with planned completion dates, as detailed in the attached report.

Thomas Wisnieski, MPA, FACHE

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 FPPEs for newly hired licensed independent practitioners are consistently initiated and that results are reported to the Medical Executive Committee.

Concur

Target date for completion: 3/31/2013

Facility response: A tracking mechanism has been developed to ensure FPPEs are initiated and completed for all newly hired physicians. Results of FPPEs as well as the number of FPPEs completed versus number of newly hired physicians will be reported to Medical Executive Committee on monthly basis starting January 23, 2013. Individual cases will be reviewed on an as needed basis.

Recommendation 2. We recommended that the local observation bed policy be revised to include all required elements.

Concur

Target date for completion: 3/31/2013

Facility response: The local Observation policy was revised to include a focused goal, and clear delineation of the service and physician responsible for care utilizing a template order set. The policy has been sent out for concurrence. Implementation is anticipated to be completed by March 31. 2013.

Recommendation 3. We recommended that processes be strengthened to ensure that data about observation bed use is gathered.

Concur

Target date for completion: 1/22/2013

Facility response: Data on use of observation beds is now collected (including daily observation census, admissions, discharges, bed days of care, conversion to inpatient, length of stay) and will be reported to Performance Improvement Council beginning January 22, 2013.

Recommendation 4. We recommended that processes be strengthened to ensure that staff perform continuing stay reviews for at least 75 percent of acute care patients.

Concur

Target date for completion: 3/31/2013

Facility response: A System Redesign team has been implemented to separate Discharge Planning from review of continued stays. RNs serving as Patient Care Facilitators will be performing admission and continued stay reviews for assigned teams. Monitoring of continued stay review completion will occur through the existing Performance Improvement Committee. The first report is expected January 22, 2013.

Recommendation 5. We recommended that processes be strengthened to ensure that the Emergency Effectiveness Committee reviews individual resuscitation events.

Concur

Target date for completion: Completed

Facility response: Members of Emergency Effectiveness Committee are now reviewing individual events and will report to Emergency Effectiveness Committee by February 26, 2013.

Recommendation 6. We recommended that processes be strengthened to ensure that the review of EHR quality includes all services.

Concur

Target date for completion: Completed

Facility response: A representative sample of all services is now included in EHR quality reviews, and a schedule of individual services presenting quality review data at Medical Record Review Committee (MRRC) has been developed. The MRRC chairman will monitor reporting compliance.

Recommendation 7. We recommended that processes be strengthened to ensure that the blood usage review process includes the results of proficiency testing done by the laboratory.

Concur

Target date for completion: Completed

Facility response: Laboratory Proficiency testing was reported to the Transfusion Committee on November 17, 2012. Proficiency testing will continued to be reported to the Transfusion Committee on a monthly basis.

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

Concur

Target date for completion: 6/30/2013

Facility response: Dedicated nursing staff and administrative support is being requested through leadership. We anticipate that dedicated staff positions will be in place by June 30, 2013. While recruitment for this new FTEE is in process, unit-based nursing staff is available to provide nursing information as needed. Administrative support is provided by the Chief, Geriatrics and Extended Care.

Recommendation 9. 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: 1/9/2013

Facility response: Home Respiratory Care Program quarterly activity reports are included in Home Care Functional Team minutes and will be sent to the Professional Council for Chief of Staff review.

Recommendation 10. We recommended that managers initiate protected peer review for the two identified patients and complete any recommended review actions.

Concur

Target date for completion: 3/31/2013

Facility response: Protected Peer Reviews were initiated for the two patients and will be presented at Peer Review Committee on February 7, 2013. Recommended review actions will be monitored through committee until completed.

Recommendation 11. We recommended that processes be strengthened to ensure that all designated staff complete respirator fit testing.

Concur

Target date for completion: 2/15/2013

Facility response: A System Redesign team was initiated to redesign the respirator fit test program and data tracking. Compliance data is reported to the Environment of Care Committee on monthly basis.

OIG Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the OIG at (202) 461-4720.
Contributors	David Griffith, RN, FAIHQ, Team Leader Douglas Henao, MS, RD Karen McGoff-Yost, LCSW, MSW Alice Morales-Rullan, MSN, CNS Carol Torczon, ACNP, MSN Eric Lindquist, Special Agent, Office of Investigations

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

Endnotes

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

[2] References used for this topic included:
- VHA Directive 2011-007, *Required Hand Hygiene Practices*, February 16, 2011.
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