Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 12-04188-140

Combined Assessment Program Review of the Battle Creek VA Medical Center Battle Creek, Michigan

March , 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	Battle Creek VA Medical Center
FY	fiscal year
HPC	hospice and palliative care
LTHOT	long-term home oxygen therapy
NA	not applicable
NC	noncompliant
OIG	Office of Inspector General
PCCT	Palliative Care Consult Team
PR	peer review
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 eight activities. The facility's reported accomplishment was implementing three initiatives to address issues with the homeless veteran population.

Recommendations: We made recommendations in all eight of the following activities:

Quality Management: Ensure that senior leaders routinely discuss Inpatient Evaluation Center data and that the discussions are documented in the minutes of a senior-level committee. Revise the local observation bed policy to include all required elements. Ensure that conversions from observation bed status to acute admissions are consistently 30 percent or less. Complete continued stay reviews on at least 75 percent of patients in acute beds. Include all services in the review of electronic health record quality. Ensure that the quality control policy for scanning includes indexing the documents, linking scanned documents to the correct record, and image quality. Consistently complete blood/transfusion reviews at least quarterly.

Environment of Care: Ensure tables used for women's health examinations are placed with the foot facing away from the door or are shielded by privacy curtains. Require that the physical therapy clinic have exit signage.

Medication Management – Controlled Substances Inspections: Initiate actions to address the identified deficiency, and correct all deficiencies identified during annual physical security surveys. Consistently reconcile 1 day's dispensing from the pharmacy to each automated unit, and monitor compliance. Ensure that inspections are randomly scheduled with no distinguishable patterns and that compliance is monitored.

Coordination of Care – Hospice and Palliative Care: Ensure that the Palliative Care Consult Team includes a 0.25 full-time employee equivalent physician and that all hospice and palliative care staff and non-hospice and palliative care staff receive end-of-life training.

Long-Term Home Oxygen Therapy: Ensure that contracts for oxygen delivery contain the need to provide educational information on the hazards of smoking while oxygen is in use at least every 6 months after the initial delivery.

Nurse Staffing: Implement the mandated staffing methodology for nursing personnel.

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

Construction Safety: Ensure that designated employees receive initial and ongoing construction safety training and that compliance is monitored. Maintain Material Safety Data Sheet information for hazardous materials within the construction area. Ensure that contract workers wear VA-issued identification badges.

Comments

The Acting Veterans Integrated Service Network Director and Facility Director agreed with the Combined Assessment Program review findings and recommendations and provided acceptable improvement plans. (See Appendixes C and D, pages 19–27 for the full text of the Directors' comments.) We consider recommendations 6, 9, 13, 15, and 17 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 eight activities:

- QM
- EOC
- Medication Management – CS Inspections
- Coordination of Care – HPC
- LTHOT
- Nurse Staffing
- Preventable Pulmonary Embolism
- Construction Safety

We have listed the general information reviewed for each of these activities. Some of the items listed may not have been applicable to this facility because of a difference in size, function, or frequency of occurrence.

The review covered facility operations for FY 2012 and FY 2013 through November 8, 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 Battle Creek VA Medical Center, Battle Creek, Michigan,* Report No. 11-01104-252, August 15, 2011). We made a repeat recommendation in QM.

During this review, we presented crime awareness briefings for 118 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 213 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

Homeless Continuum of Care

The facility implemented three initiatives for addressing issues with the homeless veteran population. The facility participated in the VISN 11 Housing and Urban Development-Veterans Affairs Supportive Housing system redesign improvement initiative. The goal was to reduce the time it takes a homeless veteran to secure permanent housing through this program to 75 days. By the end of FY 2012, the time was reduced from 130 days to 51.75 days.

In November 2011, the facility opened a new Homeless Veterans Service Center in Grand Rapids. Services at the center include a food pantry, donated clothing, and a primary care clinic. In addition, the center has a "training kitchen" to teach veterans how to prepare nutritious meals for less. Additionally, in August 2012, the facility implemented a Homeless Patient Aligned Team, which has served a total of 42 homeless veterans.

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.	
X	There was evidence that Inpatient Evaluation Center data was discussed by senior managers.	Twelve months of Medical Executive Committee meeting minutes reviewed: • There was no evidence that Inpatient Evaluation Center data was discussed by senior leaders.
	Corrective actions from the protected PR process were reported to the PR Committee.	
	Focused Professional Practice Evaluations for newly hired licensed independent practitioners complied with selected requirements.	
X	Local policy for the use of observation beds complied with selected requirements.	• The facility's policy did not include how the service or physician responsible for the patient is determined or that each admission must have a limited severity of illness.
X	Data regarding appropriateness of observation bed use was gathered, and conversions to acute admissions were less than 30 percent.	Data for 12 months reviewed: • Eleven months of data showed that more than 30 percent of observation patients were converted to acute admissions.
X	Staff performed continuing stay reviews on at least 75 percent of patients in acute beds.	Ten months of continuing stay data reviewed: • For all 10 months, less than 75 percent of acute inpatients were reviewed.
	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.	

NC	Areas Reviewed	Findings
X	There was an EHR quality review committee, and the review process complied with selected requirements.	Twelve months of EHR Committee meeting minutes reviewed: • Not all services were included in review of EHR quality. This is a repeat finding from the previous CAP review.
	The EHR copy and paste function was monitored.	
X	Appropriate quality control processes were in place for non-VA care documents, and the documents were scanned into EHRs.	• The quality control policy for scanning did not include indexing the documents, linking scanned documents to the correct record, and image quality.
X	Use and review of blood/transfusions complied with selected requirements.	• Review of blood/transfusions was assigned to the Blood Transfusion Committee, which did not meet at least quarterly.
	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 senior leaders routinely discuss the facility's Inpatient Evaluation Center data and ensure the discussion are documented in the minutes of a senior-level committee.

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

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

4. We recommended that processes be strengthened to ensure that continued stay reviews are completed on at least 75 percent of patients in acute beds.

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

6. We recommended that the quality control policy for scanning includes indexing the documents, linking scanned documents to the correct record, and image quality.

7. We recommended that processes be strengthened to ensure that blood/transfusion reviews are consistently completed at least quarterly.

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 two CLC units, the primary care/women's health clinic, the inpatient medical unit, the urgent care clinic, one inpatient mental health unit, the audiology clinic, the occupational therapy clinic, and the physical therapy clinic. 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.	
	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 the facility 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
X	Patient privacy requirements were met.	• Not all examination tables were placed with the foot facing away from the door or were shielded by privacy curtains.
	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	
X	Fire safety requirements were met.	• Egress/exits were not clearly marked in the physical therapy unit overflow room.
	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.	

Recommendations

8. We recommended that processes be strengthened to ensure that tables used for women's health examinations are placed with the foot facing away from the door or are shielded by privacy curtains.

9. We recommended that the physical therapy clinic have exit signage.

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 9 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.	
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: • One identified deficiency had not been corrected, and managers did not have action plans or an explanation for why the item remained unresolved.
X	Instructions for inspecting automated dispensing machines were documented, included all required elements, and were followed.	Automated dispensing machine inspection instructions reviewed: • Although instructions required reconciliation of 1 day's dispensing from the pharmacy to each automated unit, this was not consistently done.
	Monthly CS inspection findings summaries and quarterly trend reports were provided to the facility Director.	
	The CS Coordinator(s) and CS inspectors were properly appointed, certified, and trained 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 9 CS areas inspected during the past 6 months reviewed: • Distinguishable patterns were identified, and most inspections were performed during the last week of the month.
	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.	

Recommendations

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

11. We recommended that processes be strengthened to ensure that 1 day's dispensing from the pharmacy to each automated unit is consistently reconciled and that compliance be monitored.

12. We recommended that processes be strengthened to ensure that inspections are randomly scheduled with no distinguishable patterns 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: • VHA policy required a 0.25 full-time employee equivalent physician, but only a 0.125 full-time employee equivalent was 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 1 had end-of-life training. • Of the 15 non-HPC staff, there was no evidence that 5 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 local policy.	

Recommendations

13. We recommended that processes be strengthened to ensure that the PCCT includes a 0.25 full-time employee equivalent physician.

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

LTHOT

The purpose of this review was to determine whether the facility complied with requirements for LTHOT in its mandated Home Respiratory Care Program.[5]

We reviewed relevant documents and 32 EHRs of patients enrolled in the home oxygen program (including 4 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.	
X	Contracts for oxygen delivery contained all required elements and were monitored quarterly.	One contract reviewed: • The need to provide educational information on the hazards of smoking while oxygen is in use at least every 6 months after the initial delivery was not incorporated in the contract.
	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

15. We recommended that processes be strengthened to ensure that contracts for oxygen delivery contain the need to provide educational information on the hazards of smoking while oxygen is in use at least every 6 months after the initial delivery.

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 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
	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.	
X	The facility completed the required steps to develop a nurse staffing methodology by September 30, 2011.	• The facility had not implemented the mandated staffing methodology for nursing personnel.
	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.	

Recommendation

16. We recommended that facility implement the mandated staffing methodology for nursing personnel.

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 14 EHRs of patients with confirmed diagnoses of pulmonary embolism[a] January 1–June 30, 2012. We also interviewed key employees. The table below shows the areas reviewed for this topic. The area marked as NC needed improvement. Items that did not apply to this facility are marked "NA."

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

Recommendation

17. We recommended that managers initiate protected PR for the one identified patient and complete any recommended review actions.

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

Construction Safety

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

We inspected the Building 84 renovation project. Additionally, we reviewed relevant documents and 14 training records (4 contractor records and 10 employee records), and we interviewed key employees and managers. The table below shows the areas reviewed for this topic. The areas marked as NC needed improvement. Items that did not apply to this facility are marked "NA."

NC	Areas Reviewed	Findings
	There was a multidisciplinary committee to oversee infection control and safety precautions during construction and renovation activities and a policy outlining the responsibilities of the committee, and the committee included all required members.	
	Infection control, preconstruction, interim life safety, and contractor tuberculosis risk assessments were conducted prior to project initiation.	
	There was documentation of results of contractor tuberculosis skin testing and of follow-up on any positive results.	
	There was a policy addressing Interim Life Safety Measures, and required Interim Life Safety Measures were documented.	
	Site inspections were conducted by the required multidisciplinary team members at the specified frequency and included all required elements.	
	Infection Control Committee minutes documented infection surveillance activities associated with the project(s) and any interventions.	
	Construction Safety Committee minutes documented any unsafe conditions found during inspections and any follow-up actions and tracked actions to completion.	
X	Contractors and designated employees received required training.	Employee and contractor training records reviewed: • Two employee records did not contain evidence of initial VHA or Occupational Safety and Health Administration Construction Safety training, and 2 employee records did not contain evidence of at least 10 hours of construction safety-related training in the past 2 years.

NC	Areas Reviewed (continued)	Findings
	Dust control requirements were met.	
	Fire and life safety requirements were met.	
X	Hazardous chemicals requirements were met.	• Material Safety Data Sheet information was not maintained within the construction area.
X	Storage and security requirements were met.	• We observed contract workers who were not wearing VA-issued identification badges.
	The facility complied with any additional elements required by VHA or local policy, or other regulatory standards.	

Recommendations

18. We recommended that processes be strengthened to ensure that designated employees receive initial and ongoing construction safety training and that compliance be monitored.

19. We recommended that processes be strengthened to ensure that Material Safety Data Sheet information for hazardous materials is maintained within the construction area.

20. We recommended that processes be strengthened to ensure that contract workers wear VA-issued identification badges.

Facility Profile (Battle Creek/515) FY 2012[b]	
Type of Organization	Secondary
Complexity Level	3-Low complexity
Affiliated/Non-Affiliated	Non-affiliated
Total Medical Care Budget in Millions	$243.9
Number of:	
• **Unique Patients**	40,056
• **Outpatient Visits**	436,727
• **Unique Employees[c] (as of last pay period in FY 2012)**	1,127
Type and Number of Operating Beds:	
• **Hospital**	81
• **CLC**	109
• **Mental Health**	92
Average Daily Census: (through August 2012)	
• **Hospital**	58
• **CLC**	91
• **Mental Health**	81
Number of Community Based Outpatient Clinics	4
Location(s)/Station Number(s)	Grand Rapids/515BY Muskegon/515GA Lansing/515GB Benton Harbor/515GC
VISN Number	11

[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	60.0	49.6	50.3	52.5	53.5	54.9
VISN	65.2	65.9	53.8	53.0	56.7	54.1
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	*	13.1	11.5	*	24.1	18.1
U.S. National	15.5	11.6	12.0	19.7	24.7	18.5

***** No data is available from the facility for this measure.

[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.

Appendix C

Acting VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: March 5, 2013

From: Acting Director, Veterans In Partnership Network (10N11)

Subject: **CAP Review of the Battle Creek VA Medical Center, Battle Creek, MI**

To: Director, Chicago Office of Healthcare Inspections (54CH)

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

Per your request, attached is the report from the Battle Creek VA Medical Center. If you have any questions, please contact Kelley Sermak, VISN 11 QMO, at 734-222-4302.

Robert P. McDivitt, FACHE/VHA-CM

Facility Director Comments

Department of Veterans Affairs **Memorandum**

Date: March 5, 2013

From: Director, Battle Creek VA Medical Center (515/00)

Subject: **CAP Review of the Battle Creek VA Medical Center, Battle Creek, MI**

To: Director, Veterans In Partnership Network (10N11)

1. I have reviewed the draft report of the Inspector General's Combined Assessment Program (CAP) of the Battle Creek VA Medical Center. We concur with all the findings and recommendations.

2. I appreciate the opportunity for this review as a continuing process to improve the care to our Veterans. Thank you.

Mary Beth Skupien, Ph.D.

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 senior leaders routinely discuss the facility's Inpatient Evaluation Center data and ensure the discussions are documented in the minutes of a senior-level committee.

Concur

Target date for completion: May 31, 2013

Facility response: Inpatient Evaluation Center data is discussed and documented in the facility Quality Board on a quarterly basis. Following the February 4, 2013 meeting of the Board, three quarters of Inpatient Evaluation Center data will have been discussed with facility leadership.

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

Concur

Target date for completion: April 1, 2013

Facility response: Policy revisions were drafted and the policy is in the routing process for comments.

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: September 30, 2013

Facility response: The Utilization Review nurses are using Inter-Qual Criteria to determine if Observation is an appropriate level of care for each admission and discussing their recommendation with the providers during the prospective review process. The Utilization Management Committee is tracking the data and discussing data drill downs at committee meetings and monitoring progress.

Recommendation 4. We recommended that processes be strengthened to ensure that continued stay reviews are completed on at least 75 percent of patients in acute beds.

Concur

Target date for completion: September 30, 2013

Facility response: The Utilization Management Program staff have performed multiple tests of changes to achieve the expected performance targets for review, including but not limited to: using paperless tracking for efficiency of copy pasting chart review information (this also serves as a contingency plan for capturing data and preserving it for copy and paste later when National Utilization Management Integration problems are experienced); staff attending a bed huddle for Mental Health in lieu of attending treatment team meetings. Utilization Management Program staff are also being cross trained to assist with review completion. January data per VSSC shows Battle Creek at 80.2% of continued stay reviews completed. These reviews will continue to be monitored to ensure processes are stable.

Recommendation 5. We recommended that processes be strengthened to ensure that the review of EHR quality includes all services.

Concur

Target date for completion: September 30, 2013

Facility response: Services were surveyed on the types of record reviews completed at the Service level and an annual reporting schedule was developed to require Services to report twice per year to the Medical Records Committee on the outcome of the Service quality reviews. The Service reporting will begin at the March 7, 2013, Medical Records Committee meeting and will continue to be monitored to ensure processes are stable.

Recommendation 6. We recommended that the quality control policy for scanning includes indexing the documents, linking scanned documents to the correct record, and image quality.

Concur

Target date for completion: Completed

Facility response: The quality control policy on Document Scanning was updated to include indexing the documents, linking scanned documents to the correct record, and image quality.

Recommendation 7. We recommended that processes be strengthened to ensure that blood/transfusion reviews are consistently completed at least quarterly.

Concur

Target date for completion: September 30, 2013

Facility response: The Blood Transfusion Committee (Blood Usage Review Committee) has established a specific date and time that the Committee will meet and complete blood/transfusion reviews. This meeting will be held quarterly on the second Thursday of the second month of each quarter.

Recommendation 8. We recommended that processes be strengthened to ensure that tables used for women's health examinations are placed with the foot facing away from the door or are shielded by privacy curtains.

Concur

Target date for completion: September 30, 2013

Facility response: A random inspection of exam table placement in exam rooms at the Battle Creek VA Medical Facility was conducted by the Women Veterans Program Manager on December 10, 2012 and January 14, 2013. All exam tables were in the proper position per policy. Random monitoring will continue to ensure ongoing compliance.

Recommendation 9. We recommended that the physical therapy clinic have exit signage.

Concur

Target date for completion: Completed

Facility response: Facilities Management Service ordered the required materials and completed the installation of two additional exit signs.

Recommendation 10. We recommended that managers initiate actions to address the identified deficiency and that processes be strengthened to ensure that all deficiencies identified during annual physical security surveys are corrected.

Concur

Target date for completion: March 8, 2013

Facility response: A Work Order was submitted, local Engineering Service completed the work, and all Pharmacy doors (Building 2 & 4) have been repaired. They now meet minimum physical security requirements for access.

In the future the Chief, Police Service, will ensure that deficiencies are noted during the Annual Physical Security Surveys and corrective actions or action plans are submitted in the required 30 day period per VA policy. Any deficiencies noted that have not been corrected or do not have a Service action plan submitted will be brought to the attention of the Facility Management through submission of an emergency work order and will be corrected within 3 days. A facility checklist was created to aid in ensuring all problems are addressed in a timely manner and within the policy Directive.

Recommendation 11. We recommended that processes be strengthened to ensure that 1 day's dispensing from the pharmacy to each automated unit is consistently reconciled and that compliance be monitored.

Concur

Target date for completion: September 30, 2013

Facility response: Controlled Substance Inspector worksheets and competency checklists have been modified, adding the requirement to reconcile one day's worth of pharmacy stocking activity for each automated dispensing unit. Pharmacy has been instructed to provide the Controlled Substance Inspector's documentation pertaining to the stocking activity for each automated dispensing unit occurring 14 days prior to the scheduled inspection. The Controlled Substance Security Official and the Assistant Controlled Substance Security Official will monitor this requirement monthly, ensuring proper documentation is retained, and any noted discrepancies are reported to the Medical Center Director for action plans and follow up.

Recommendation 12. We recommended that processes be strengthened to ensure that inspections are randomly scheduled with no distinguishable patterns and that compliance be monitored.

Concur

Target date for completion: September 30, 2013

Facility response: The Controlled Substance Security Official (CSSO) and the Assistant Controlled Substance Security Official (ACSSO) have ensured that inspections are called in a random manner. The CSSO/ACSSO schedules inspections and monitors that the inspections are not held on the same day of the week or the same week of the month for two consecutive months.

Recommendation 13. We recommended that processes be strengthened to ensure that the PCCT includes a 0.25 full-time employee equivalent physician.

Concur

Target date for completion: Completed

Facility response: Primary Care Service has a Physician assigned as a .25 FTEE to PCCT.

Recommendation 14. 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: September 30, 2013

Facility response: Palliative care education continues to be a priority in this facility. Hospice and Palliative Care staff training via the End of Life Nursing Education Consortium's (ELNEC) Veteran End-of-life education modules have been placed in our Talent Management System (TMS) online, so the modules could be automatically assigned to the proper personnel to be completed within 90 days of hire date and every 3 years thereafter. Additionally, the Palliative Care TMS education module that should be assigned annually to all Medical Center staff is being double checked for accuracy regarding proper staff assignments as an oversight in assignment is what caused the non-HPC staff fallouts. The Palliative Care Program Coordinator will now analyze assignment and completion reports for the following TMS modules on a monthly basis: ELNEC Veteran End-of-life Care education modules for RNs and LPNs in the Community Living Center, Hospice and Palliative Nursing Association (HPNA) Veteran End-of-Life Care education modules for Nursing Assistants in the Community Living Center, and the Palliative Care education module for all Medical Center clinical staff. Missing module assignments will be reported to the Chief of Learning Resources for proper assignment and overdue assignments will be reported to the employee's supervisor to ensure timely completion. A detailed action plan has been created and results will be monitored.

Recommendation 15. We recommended that processes be strengthened to ensure that contracts for oxygen delivery contain the need to provide educational information on the hazards of smoking while oxygen is in use at least every 6 months after the initial delivery.

Concur

Target date for completion: Completed

Facility response: The Home Oxygen Contract was bilaterally modified on November 7, 2012, to include "The Contractor shall provide education to each patient at the time of set-up and every six months thereafter, and assess the need for reinforcement during visits."

Recommendation 16. We recommended that facility implement the mandated staffing methodology for nursing personnel.

Concur

Target date for completion: July 31, 2013

Facility response: The mandated staffing methodology for nursing personnel, including facility and unit level expert panel training, will be fully implemented by July 31, 2013. All plans will include facility expert panel and Medical Center Director concurrence.

Recommendation 17. We recommended that managers initiate protected PR for the one identified patient and complete any recommended review actions.

Concur

Target date for completion: Completed

Facility response: Peer review was initiated on November 6, 2012, and completed on November 8, 2012.

Recommendation 18. We recommended that processes be strengthened to ensure that designated employees receive initial and ongoing construction safety training and that compliance be monitored.

Concur

Target date for completion: September 30, 2013

Facility response: A live 10 hour OSHA Construction Safety training class has been scheduled through the Army Corp of Engineers for February 28, 2013, to assist the remaining employees in completion of the required training. Compliance will continue to be monitored with both current and new employees.

Recommendation 19. We recommended that processes be strengthened to ensure that Material Safety Data Sheet information for hazardous materials is maintained within the construction area.

Concur

Target date for completion: September 30, 2013

Facility response: A reminder to check for the presence of the contractor's Material Safety Data Sheets (MSDS) has been added to daily inspection checklist used by the Contracting Officers Representatives assigned to oversee construction projects. Processes will continue to be monitored to ensure ongoing compliance.

Recommendation 20. We recommended that processes be strengthened to ensure that contract workers wear VA-issued identification badges.

Concur

Target date for completion: September 30, 2013

Facility response: A reminder to check for the presence of the contractor's VA-issued identification badges has been added to daily inspection checklist used by the Contracting Officers Representatives assigned to oversee construction projects. Processes will continue to be monitored to ensure ongoing compliance.

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