Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 13-00273-147

Combined Assessment Program Review of the John J. Pershing VA Medical Center Poplar Bluff, Missouri

March 26, 2013

Washington, DC 20420

To Report Suspected Wrongdoing in VA Programs and Operations
Telephone: 1-800-488-8244
E-Mail: vaoighotline@va.gov
(Hotline Information: www.va.gov/oig/hotline)

Glossary

CAP	Combined Assessment Program
CLC	community living center
CS	controlled substances
EHR	electronic health record
EKG	electrocardiogram
EOC	environment of care
facility	John J. Pershing VA Medical Center
FY	fiscal year
HPC	hospice and palliative care
MI	myocardial infarction
NA	not applicable
NC	noncompliant
OIG	Office of Inspector General
PCCT	Palliative Care Consult Team
QM	quality management
STEMI	ST-elevation myocardial infarction
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 January 7, 2013.

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

- Medication Management – Controlled Substances Inspections
- Preventable Pulmonary Embolism

The facility's reported accomplishment was improved emergency cardiac care for veterans.

Recommendations: We made recommendations in the following five activities:

Quality Management: Ensure that the Clinical Safety Committee reviews each code episode and that code reviews include screening for clinical issues prior to non-intensive care unit codes that may have contributed to the occurrence of the code. Include all services in the review of electronic health record quality. Develop and implement a policy that details quality control for scanning into electronic health records. Ensure that the Transfusion Review Committee meets quarterly and that the blood usage review process includes consistent reporting of data and the results of proficiency testing and peer reviews. Require that actions taken when data analyses indicated problems or opportunities for improvement are consistently followed to resolution for outcomes from resuscitation, electronic health record reviews, blood/transfusion reviews, and system redesign.

Environment of Care: Ensure that actions are implemented to address high-risk areas and that Clinical Safety Committee minutes document these actions. Develop and implement a policy that details cleaning of equipment between patients, and monitor compliance with the policy. Track identified women's health-related deficiencies to closure.

Coordination of Care – Hospice and Palliative Care: Implement a Palliative Care Consult Team that complies with Veterans Health Administration requirements. Ensure all hospice and palliative care staff and non-hospice and palliative care staff receive end-of-life training. Require the community living center-based hospice program to offer bereavement services to patients and families. Establish a process to track hospice and palliative care consults that are not acted upon within 7 days of the request.

Long-Term Home Oxygen Therapy: Re-evaluate home oxygen program patients for home oxygen therapy annually after the first year. Ensure high-risk home oxygen patients receive education on the hazards of smoking while oxygen is in use at the

required intervals, and document the education. Assess all new home oxygen patients for continuation of home oxygen within 90 days of the initial order. Notify the home oxygen vendor when a patient is identified by the facility as being a high-risk smoker.

Nurse Staffing: Implement all the required processes for the staffing methodology for nursing personnel.

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 17–24, for the full text of the Directors' comments.) We will follow up on the planned actions until they are completed.

JOHN D. DAIGH, JR., M.D.
Assistant Inspector General for
Healthcare Inspections

Objectives and Scope

Objectives

CAP reviews are one element of the OIG's efforts to ensure that our Nation's veterans receive high quality VA health care services. The objectives of the CAP review are to:

- Conduct recurring evaluations of selected health care facility operations, focusing on patient care quality and the EOC.
- Provide crime awareness briefings to increase employee understanding of the potential for program fraud and the requirement to refer suspected criminal activity to the OIG.

Scope

We reviewed selected clinical and administrative activities to evaluate compliance with requirements related to patient care quality and the EOC. In performing the review, we inspected selected areas, interviewed managers and employees, and reviewed clinical and administrative records. The review covered the following 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 January 10, 2013, and was done in accordance with OIG standard operating procedures for CAP reviews. We also asked the facility to provide the status on the recommendations we made in our previous CAP report (*Combined Assessment Program Review of the John J. Pershing VA Medical Center, Poplar Bluff, Missouri,* Report No. 10-02994-103, February 24, 2011). We made a repeat recommendation in QM.

During this review, we presented crime awareness briefings for 37 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 107 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

Improved Emergency Cardiac Care for Veterans – "Code STEMI"

In March 2011, the facility implemented a new process named "Code STEMI" to dramatically improve care for veterans experiencing an acute MI. The facility is located in a rural setting, 150 miles from the nearest VA facility that provides invasive cardiac services. This created a challenge when trying to meet the standard of care for patients who should receive a cardiac catheterization within 90 minutes of symptom onset.

To address this barrier, the facility implemented a collaborative agreement with a local non-VA hospital. Veterans who present to the facility's urgent care department with chest pain are rapidly triaged and undergo cardiac assessment, including an EKG. The EKG result is immediately transmitted by fax to the local non-VA hospital emergency department. The non-VA emergency department provider interprets the EKG, and if it is indicative of an acute MI, the VA urgent care provider is notified, and an ambulance is dispatched to transfer the veteran to the local non-VA hospital. Simultaneous to these events, the non-VA hospital activates their cardiac surgeon and cardiac catheterization team. VA staff provide hand-off communication to the non-VA cardiac care team, and upon arrival at the non-VA hospital, the veteran immediately undergoes emergent cardiac catheterization.

Since the implementation of "Code STEMI," 100 percent of veterans who have presented experiencing an acute MI have had blood flow restored to tissue within the recommended 90-minute timeframe, with an average turn-around-time of 66 minutes. The facility has received two awards for this project.

Results and Recommendations

QM

The purpose of this review was to determine whether facility senior managers actively supported and appropriately responded to QM efforts and whether the facility complied with selected requirements within its QM program.[1]

We interviewed senior managers and key QM employees, and we evaluated meeting minutes, EHRs, and other relevant documents. The table below shows the areas reviewed for this topic. The areas marked as NC needed improvement. Items that did not apply to this facility are marked "NA."

NC	Areas Reviewed	Findings
	There was a senior-level committee/group responsible for QM/performance improvement, and it included the required members.	
	There was evidence that Inpatient Evaluation Center data was discussed by senior managers.	
	Corrective actions from the protected peer review process were reported to the Peer Review Committee.	
	Focused Professional Practice Evaluations for newly hired licensed independent practitioners complied with selected requirements.	
	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 on at least 75 percent of patients in acute beds.	
NA	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.	Four quarters of Clinical Safety Committee meeting minutes reviewed: • There was no consistent documentation that the committee reviewed each code episode. This was a repeat finding from the previous CAP review. • There was no evidence that the recently implemented code review process included screening for clinical issues prior to non-intensive care unit codes that may have contributed to the occurrence of the code.

NC	Areas Reviewed (continued)	Findings
X	There was an EHR quality review committee, and the review process complied with selected requirements.	Four quarters of EHR Committee meeting minutes reviewed: • Not all services were included in review of EHR quality.
	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.	• There is no quality control policy for scanning.
X	Use and review of blood/transfusions complied with selected requirements.	Three quarters of Transfusion Review Committee meeting minutes reviewed: • The committee did not meet quarterly. • The review process did not include consistent reporting of data and the results of proficiency testing and peer reviews.
	CLC minimum data set forms were transmitted to the data center with the required frequency.	
X	Overall, if significant issues were identified, actions were taken and evaluated for effectiveness.	• Corrective actions were not consistently followed to resolution for outcomes from resuscitation, EHR reviews, blood/transfusion reviews, and system redesign.
	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 the Clinical Safety Committee reviews each code episode and that code reviews include screening for clinical issues prior to non-intensive care unit codes that may have contributed to the occurrence of the code.

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

3. We recommended that facility managers develop and implement a policy that details quality control for scanning into EHRs.

4. We recommended that the Transfusion Review Committee meets quarterly and that processes be strengthened to ensure that the blood usage review process includes consistent reporting of data and the results of proficiency testing and peer reviews.

5. We recommended that processes be strengthened to ensure that actions taken when data analyses indicated problems or opportunities for improvement are consistently followed to resolution for outcomes from resuscitation, EHR reviews, blood/transfusion reviews, and system redesign.

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 inpatient units (acute care and CLC), outpatient clinics (physical therapy, primary care, specialty care, and women's health), and urgent care. 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.	
X	An infection prevention risk assessment was conducted, and actions were implemented to address high-risk areas.	Infection prevention risk assessment and 6 months of Clinical Safety Committee meeting minutes reviewed: • Minutes did not reflect that 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.	
X	The facility had a policy that detailed cleaning of equipment between patients.	• The facility did not have a policy.
	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	
X	The Women Veterans Program Manager completed required annual EOC evaluations, and the facility tracked women's health-related deficiencies to closure.	Documentation of 1 semiannual EOC rounds, 12 months of Women Veterans Health Committee meeting minutes, the annual Women Veterans Program Manager EOC evaluation, and tracking documentation reviewed: • The facility did not track identified women's health-related deficiencies to closure.

NC	Areas Reviewed for the Women's Health Clinic (continued)	Findings
	Fire safety requirements were met.	
	Environmental safety requirements were met.	
	Infection prevention requirements were met.	
	Medication safety and security requirements were met.	
	Patient privacy requirements were met.	
	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.	
	Areas Reviewed for Physical Medicine and Rehabilitation Therapy Clinics	
	Fire safety requirements were met.	
	Environmental safety requirements were met.	
	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

6. We recommended that processes be strengthened to ensure that actions are implemented to address high-risk areas and that Clinical Safety Committee minutes document those actions.

7. We recommended that facility managers develop and implement a policy that details cleaning of equipment between patients and that compliance with the policy be monitored.

8. We recommended that processes be strengthened to ensure that identified women's health-related deficiencies are tracked to closure.

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 6 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), 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.	• A PCCT was not in place.
NA	The PCCT actively sought patients appropriate for HPC.	
NA	The PCCT offered end-of-life training.	
X	HPC staff and selected non-HPC staff had end-of-life training.	• There was no evidence that any of the 10 HPC staff or 15 non-HPC staff had end-of-life training.
	The facility had a VA liaison with community hospice programs.	
NA	The PCCT promoted patient choice of location for hospice care.	
X	The CLC-based hospice program offered bereavement services.	• We did not find evidence that the CLC offered bereavement services to patients and families.
	The HPC consult contained the word "palliative" or "hospice" in the title.	
	HPC consults were submitted through the Computerized Patient Record System.	
X	The PCCT responded to consults within the required timeframe and tracked consults that had not been acted upon.	• Three consults were not acted upon by facility staff within 7 days of the request and had not been tracked.
	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.	

Recommendations

9. We recommended that the facility implement a PCCT that complies with VHA requirements.

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

11. We recommended that processes be strengthened to ensure that the CLC-based hospice program offers bereavement services to patients and families.

12. We recommended that a process be established to track HPC consults that are not acted upon within 7 days of the request.

Long-Term Home Oxygen Therapy

The purpose of this review was to determine whether the facility complied with requirements for long-term home oxygen therapy in its mandated Home Respiratory Care Program.[5]

We reviewed relevant documents and 34 EHRs of patients enrolled in the home oxygen program (including 9 patients deemed to be high risk), and we interviewed key employees. The table below shows the areas reviewed for this topic. The 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.	
	The Chief of Staff reviewed Home Respiratory Care Program activities at least quarterly.	
	The facility had established a home respiratory care team.	
	Contracts for oxygen delivery contained all required elements and were monitored quarterly.	
X	Home oxygen program patients had active orders/prescriptions for home oxygen and were re-evaluated for home oxygen therapy annually after the first year.	• Five EHRs (15 percent) contained no documentation of a re-evaluation after the first year.
X	Patients identified as high risk received hazards education at least every 6 months after initial delivery.	• Two high-risk patients' EHRs did not contain documentation of education on the hazards of smoking while oxygen is in use at the required intervals.
	NC high-risk patients were identified and referred to a multidisciplinary clinical committee for review.	
X	The facility complied with any additional elements required by VHA or local policy.	• Nineteen home oxygen program patients were not assessed for continuation of home oxygen within 90 days of the initial order in accordance with local policy. • The home oxygen vendor was not notified when a patient was identified by the facility as being a high-risk smoker, as required by local policy.

Recommendations

13. 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.

14. We recommended that processes be strengthened to ensure that high-risk home oxygen patients receive education on the hazards of smoking while oxygen is in use at the required intervals and that the education is documented.

15. We recommended that processes be strengthened to ensure that all new home oxygen patients are assessed for continuation of home oxygen within 90 days of the initial order.

16. We recommended that processes be strengthened to ensure that the home oxygen vendor is notified when a patient is identified by the facility as being a high-risk smoker.

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 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
NA	The unit-based expert panels followed the required processes.	
NA	The facility expert panel followed the required processes and included all required members.	
NA	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.	• Expert panels were not convened until October 1, 2012.
NA	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

17. We recommended that nursing managers implement all the required processes for the 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 five 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. Items that did not apply to this facility are marked "NA." The facility generally met requirements. We made no recommendations.

NC	Areas Reviewed	Findings
	Patients with potentially preventable pulmonary emboli received appropriate anticoagulation medication prior to the event.	
	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.	

[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 (Poplar Bluff/657A4) FY 2012[b]	
Type of Organization	Tertiary
Complexity Level	3-Low complexity
Affiliated/Non-Affiliated	Non-affiliated
Total Medical Care Budget in Millions	$114.7
Number of:	
• **Unique Patients**	20,141
• **Outpatient Visits**	210,205
• **Unique Employees[c] (as of last pay period in FY 2012)**	320
Type and Number of Operating Beds:	
• **Hospital**	18
• **CLC**	40
• **Mental Health**	0
Average Daily Census: (through August 2012)	
• **Hospital**	11
• **CLC**	30
• **Mental Health**	NA
Number of Community Based Outpatient Clinics	6
Location(s)/Station Number(s)	West Plains, MO/657GF Paragould, AR/657GG Cape Girardeau, MO/657GH Farmington, MO/657GI Salem, MO/657GN Sikeston, MO/657VG
VISN Number	15

[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	61.4	51.2	55.2	57.8	60.8
VISN	57.8	56.8	51.7	53.0	55.0	55.8
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	16.0	11.6	10.1	**	28.7	17.7
U.S. National	15.5	11.6	12.0	19.7	24.7	18.5

****** The number of cases is too small (fewer than 25) to reliably tell how well the facility is performing.

[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: March 11, 2013

From: Director, VA Heartland Network (10N15)

Subject: **CAP Review of the John J. Pershing VA Medical Center, Poplar Bluff, MO**

To: Director, Kansas City Office of Healthcare Inspections (54KC)

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

Attached, please find the initial status response for the Combined Assessment Program Review of the John J. Pershing VA Medical Center, Poplar Bluff, MO.

I have reviewed and concur with the Medical Center Director's response. Thank you for this opportunity of review focused towards continuous performance improvement.

For additional questions, please feel free to contact Jimmie Bates, VISN 15 Quality Management Officer at (816) 701-3014.

William P. Patterson, MD, MSS
Network Director
VA Heartland Network (VISN 15)

Facility Director Comments

Department of Veterans Affairs **Memorandum**

Date: March 4, 2013

From: Director, John J. Pershing VA Medical Center (657A4/00)

Subject: **CAP Review of the John J. Pershing VA Medical Center, Poplar Bluff, MO**

To: Director, VA Heartland Network (10N15)

1. Attached, please find John J. Pershing VA Medical Center's status report for the Office of Inspector General Combined Assessment Program (OIG-CAP) review conducted during the week of January 7, 2013.

2. If you have any questions regarding the information provided, please contact Dawna Bader, Director of Performance Improvement. Ms. Bader can be reached at (573) 778-4280.

(original signed by:)
Marj Hedstrom
Medical Center 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 processes be strengthened to ensure that the Clinical Safety Committee reviews each code episode and that code reviews include screening for clinical issues prior to non-intensive care unit codes that may have contributed to the occurrence of the code.

Concur

Target date for completion: Completed

In December 2012, the responsibility for reviewing cardiopulmonary resuscitation events was transferred from the Clinical Safety Committee (CSC) to a newly formed Cardiopulmonary Resuscitation Committee (CRC). CRC membership includes all required disciplines who review each individual episode where resuscitation was attempted in compliance with VHA Directive 2008-063, Oversight and Monitoring of Cardiopulmonary Resuscitative Events and Facility Cardiopulmonary Resuscitation Committee, including screening for clinical issues prior to the code event that may have contributed to the arrest. The CRC also analyzes aggregate code data to identify adverse trends. When individual issues or adverse trends are identified, the CRC makes recommendations for improvement and ensures corrective actions are implemented. The CRC reports directly to the Clinical Practice Council on a monthly basis.

Recommendation 2. We recommended that processes be strengthened to ensure that the review of EHR quality includes all services.

Concur

Target date for completion: May 31, 2013

Research is underway to locate medical record review tools for those specialty services not currently represented in the medical record review program. If suitable tools cannot be located, they will be developed. Once located and/or developed, they will be implemented and included in the EHR quality-monitoring program.

Recommendation 3. We recommended that facility managers develop and implement a policy that details quality control for scanning into EHRs.

Concur

Target date for completion: April 30, 2013

Scanning Policy, PM-001-136D-14 has been developed and is pending final review and approval. The new policy outlines requirements for scanning clinical reports into the EHR, including non-VA records of care, and includes controls for these documents.

Recommendation 4. We recommended that the Transfusion Review Committee meets quarterly and that processes be strengthened to ensure that the blood usage review process includes consistent reporting of data and the results of proficiency testing and peer reviews.

Concur

Target date for completion: Completed

The Transfusion Utilization Committee (TUC) has met quarterly for the past 6 months and will continue to do so. Proficiency testing and peer review were added to the ongoing blood usage review monitor in January 2013. The results from this monitor are reviewed by the TUC no less than quarterly. Finally, minutes from the TUC will be randomly monitored as part of the monitor discussed in the facility response to Recommendation 5 to ensure their minutes reflect appropriate discussion, that action items are tracked through closure, and that they are meeting with the required frequency.

Recommendation 5. We recommended that processes be strengthened to ensure that actions taken when data analyses indicated problems or opportunities for improvement are consistently followed to resolution for outcomes from resuscitation, EHR reviews, blood/transfusion reviews, and system redesign.

Concur

Target date for completion: May 31, 2013

Various councils/committees across the medical center have oversight responsibility for reviewing specific data outcomes such as those from resuscitation, EHR reviews, blood transfusion reviews, system redesign, etc. However, there exists a variable degree of skill in documenting the council/committee review of outcome data and documenting/tracking improvement actions in their minutes. In February 2013, the facility initiated a deep dive to review the existing council/committee (governance) structure and revise it as indicated, including making recommendations on council/committee chairs and membership. Once the governance structure is finalized and chairpersons identified, both council/committee chairpersons and recorders (if available) will be required to complete a 3-tiered training program to build their skills in: holding effective meetings; documenting meeting minutes to capture key discussion points; and identifying and tracking action items through closure. Training courses are scheduled to begin in March 2013. Finally, a monitor will be established to review random sets of minutes from all council/committees to ensure the training was effective (their minutes reflect appropriate discussion and tracking of action items through closure) and that they are meeting with the required frequency.

Recommendation 6. We recommended that processes be strengthened to ensure that actions are implemented to address high-risk areas and that Clinical Safety Committee minutes document those actions.

Concur

Target date for completion: May 31, 2013

At the time of this survey, the CSC was charged with carrying out multiple programmatic functions that typically would have been performed by independent committees, such as (among others) an Infection Control Committee (ICC) and a CRC. Upon review, it was determined that it was too difficult for one committee, such as the CSC to carry out all of these high-risk functions, and that individual committees were needed. Therefore, separate committees were established for both ICC and CRC. These newly formed committees report directly to the Clinical Practice Council and the CSC is undergoing review as part of the governance restructure as identified in the facility response to Recommendation 5. Findings from the restructure will determine the future purpose and design of the CSC. Finally, minutes from the CSC, ICC, and CRC committees will be randomly monitored as part of the monitor discussed in the facility response to Recommendation 5 (random monitoring to ensure their minutes reflect appropriate discussion, that action items are tracked through closure, and that they are meeting with the required frequency). For ICC, this random review will also include ensuring that actions are implemented to address high-risk areas.

Recommendation 7. We recommended that facility managers develop and implement a policy that details cleaning of equipment between patients and that compliance with the policy be monitored.

Concur

Target date for completion: April 31, 2013

PM 118-113, Management and Cleaning of Non-Critical Reusable Medical Equipment in Patient Care Areas was approved and published on March 4, 2013. Compliance with this policy will be assessed during routine EOC rounds and ad hoc monitoring with results reported through the ICC.

Recommendation 8. We recommended that processes be strengthened to ensure that identified women's health-related deficiencies are tracked to closure.

Concur

Target date for completion: Completed

Results of veteran women's health-related deficiencies and subsequent corrective action plans will be reported at least quarterly through the Women Veterans Advisory Committee (WVAC). Minutes from the WVAC will be randomly monitored as part of the monitor discussed in the facility response to Recommendation 5 (random monitoring to

ensure their minutes reflect appropriate discussion, that action items are tracked through closure, and that they are meeting with the required frequency).

Recommendation 9. We recommended that the facility implement a PCCT that complies with VHA requirements.

Concur

Target date for completion: May 31, 2013

A full-time HPC Coordinator position has been approved and is pending hire. The HPC will serve as the Palliative Care Coordinator (PCC) and be responsible for compliance with all requirements of the HPC program. Until the HPC Coordinator is hired, on December 6, 2012, an interim HPC was assigned to initiate a review of the outstanding palliative care consults, and to evaluate and address the needs of hospice and palliative care patients. The PCCT is being restructured and will include all required disciplines.

Recommendation 10. 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: May 31, 2013

Once the PCCT staff are identified, both they and the existing HPC/non-HPC staff will undergo the requisite end-of-life training (currently, 30% have been trained).

Recommendation 11. We recommended that processes be strengthened to ensure that the CLC-based hospice program offers bereavement services to patients and families.

Concur

Target date for completion: May 31, 2013

The CLC will develop and implement bereavement services which will be offered to end-of-life patients and their families.

Recommendation 12. We recommended that a process be established to track HPC consults that are not acted upon within 7 days of the request.

Concur

Target date for completion: May 31, 2013

HPC consults will be tracked by the HPC Coordinator and monitored as part of the facility's ongoing consult tracking monitor. Additionally, HPC consults that are not acted upon within 7 days of the request will be reported to the facility's senior leadership during the bi-weekly management data briefing.

Recommendation 13. 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: April 30, 2013

Education will be provided to the Patient Aligned Care Team (PACT) on home oxygen annual requirements and guidelines. A memo will be sent to home oxygen patients' PACT one month prior to their oxygen order expiration. The PACT will be required to document reevaluation of the patient and continued need for oxygen therapy before home oxygen services will be continued.

Recommendation 14. We recommended that processes be strengthened to ensure that high-risk home oxygen patients receive education on the hazards of smoking while oxygen is in use at the required intervals and that the education is documented.

Concur

Target date for completion: April 30, 2013

All home oxygen patients (not just those deemed 'high-risk') will be provided an educational packet which focuses on safety and smoking hazards. Education will be provided both when home oxygen is first initiated and every 6 months thereafter. The provision of this education will be documented in the EHR, and a random, monthly audit will be initiated to ensure patients are receiving education and it is being documented in the EHR at the appropriate intervals.

Recommendation 15. We recommended that processes be strengthened to ensure that all new home oxygen patients are assessed for continuation of home oxygen within 90 days of the initial order.

Concur

Target date for completion: April 30, 2013

Education will be provided to the PACT on home oxygen annual requirements and guidelines, including the requirement that patients be reassessed within 90 days of initial order to determine if oxygen therapy should be continued or discontinued based upon assessment findings. A consult alert will be sent to home oxygen patients' PACT before the end of the 90-day period and the team will be required to document reevaluation of the patient and continued need for oxygen therapy before home oxygen services will be continued.

Recommendation 16. We recommended that processes be strengthened to ensure that the home oxygen vendor is notified when a patient is identified by the facility as being a high-risk smoker.

Concur

Target date for completion: April 30, 2013

'High-risk' designation is needed for the Home Oxygen Contractor to identify which patients require education on the hazards of smoking with oxygen. However, the facility's Home Oxygen Committee determined that all patients, not just those who smoke, need to have education on home oxygen safety and the hazards of smoking with oxygen because individuals that smoke may come to patients' homes, and there are other open flame risks that could place non-smoking patients at high risk. Therefore, the decision was made to include all home oxygen patients in the high-risk category, and to provide them with education initially and bi-annually thereafter (refer to action under Recommendation 14). As a result, the facility's Home Oxygen Consult will be modified to automatically populate the response to the smoking assessment with "yes," thus triggering the need for education by the Home Oxygen Contractor.

Recommendation 17. We recommended that nursing managers implement all the required processes for the staffing methodology for nursing personnel.

Concur

Target date for completion: Completed

Expert panels met and made recommendations for staffing. OP 118-44, Staffing Methodology Policy was approved and published on March 4, 2013, and relevant staff was educated on the new policy prior to its publication. Unit staff and expert panels completed required Staffing Methodology Training. Unit-based Hours Per Patient Day (HPPD) have been established and are monitored daily.

OIG Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the OIG at (202) 461-4720.
Contributors	James Seitz, RN, MBA, Team Leader Dorothy Duncan, RN, MHA Cindy Niemack-Brown, CMSW, LMHP Larry Selzler, MSPT Laura Snow, LMSW, MHCL Jennifer Whitehead, Program Support Assistant Greg Billingsley, Office of Investigations

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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; VHA Handbook 1142.03, *Requirements for Use of the Resident Assessment Instrument (RAI) Minimum Data Set (MDS)*, January 4, 2013.

[2] References used for this topic included:
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- 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:
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- 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.
- VHA Directive 2008-056, *VHA Consult Policy*, September 16, 2008.
- VHA Handbook 1004.02, *Advanced Care Planning and Management of Advance Directives*, July 2, 2009.
- VHA Handbook 1142.01, *Criteria and Standards for VA Community Living Centers (CLC)*, August 13, 2008.
- VHA Directive 2009-053, *Pain Management*, October 28, 2009.
- Under Secretary for Health, "Hospice and Palliative Care are Part of the VA Benefits Package for Enrolled Veterans in State Veterans Homes," Information Letter 10-2012-001, January 13, 2012.

[5] References used for this topic were:
- VHA Directive 2006-021, *Reducing the Fire Hazard of Smoking When Oxygen Treatment is Expected*, May 1, 2006.
- VHA Handbook 1173.13, *Home Respiratory Care Program*, November 1, 2000.

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

[7] The reference used for this topic was:

- VHA Office of Analytics and Business Intelligence, *External Peer Review Technical Manual*, FY2012 quarter 4, June 15, 2012, p. 80–98.