Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 13-00275-149

Combined Assessment Program Review of the Chillicothe VA Medical Center Chillicothe, Ohio

March 27, 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
COS	Chief of Staff
CPR	cardiopulmonary resuscitation
CS	controlled substances
EHR	electronic health record
EOC	environment of care
facility	Chillicothe VA Medical Center
FPPE	Focused Professional Practice Evaluation
FY	fiscal year
HPC	hospice and palliative care
HRCP	Home Respiratory Care Program
NA	not applicable
NC	noncompliant
OIG	Office of Inspector General
PCCT	Palliative Care Consult Team
QM	quality management
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Table of Contents

Executive Summary

Review Purpose: The purpose of the review was to evaluate selected health care facility operations, focusing on patient care quality and the environment of care, and to provide crime awareness briefings. We conducted the review the week of January 14, 2013.

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

- Environment of Care
- Nurse Staffing

The facility's reported accomplishment was the success of its bed turn-around time team.

Recommendations: We made recommendations in the following five activities:

Quality Management: Consistently complete Focused Professional Practice Evaluations for newly hired licensed independent practitioners. Ensure that the Cardiopulmonary Resuscitation Committee reviews each code episode. Review the quality of entries in the electronic health record. Consistently scan the results of non-VA purchased diagnostic tests into electronic health records. Ensure that actions taken when data analyses indicate problems are consistently followed to resolution for Inpatient Evaluation Center data, utilization management, outcomes from resuscitation, copy and paste, and blood/transfusion reviews.

Medication Management – Controlled Substances Inspections: Validate two transfers of controlled substances from one storage area to another, and monitor compliance. Ensure inspectors sign and initial inspection documents in accordance with local policy.

Coordination of Care – Hospice and Palliative Care: Include a dedicated administrative support person on the Palliative Care Consult Team. Require hospice and palliative care staff and non-hospice and palliative care staff to receive end-of-life training. Ensure the community living center-based hospice program offers bereavement services tp patients and families. Require that interdisciplinary care plans for hospice and palliative care inpatients include all elements required by local policy.

Long-Term Home Oxygen Therapy: Ensure the Chief of Staff reviews Home Respiratory Care Program activities at least quarterly. Re-evaluate home oxygen program patients for home oxygen therapy annually after the first year. Identify high-risk home oxygen patients. Ensure prescribing clinicians conduct initial and follow-up evaluations of home oxygen program patients.

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

Comments

The Veterans Integrated Service Network and Facility Directors agreed with the Combined Assessment Program review findings and recommendations and provided acceptable improvement plans. (See Appendixes C and D, pages 16–22, for the full text of the Directors' comments.) We 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 17, 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 Chillicothe VA Medical Center, Chillicothe, Ohio,* Report No. 10-00049-169, June 10, 2010).

During this review, we presented crime awareness briefings for 258 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 302 responded. We shared survey results with the facility Director.

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

Bed Turn-Around Time

In order to improve patient flow, the facility chartered a multidisciplinary team to address bed turn-around time. When the project was initiated, the average bed turn-around time was 18 hours, with 85 percent of the beds left dirty overnight. At project completion, average bed turn-around time was down to 2 hours, with almost no beds left dirty overnight. Additional benefits from the project included improved communication, eliminated rework, and improved patient safety. The new approach allows one person to complete the process all at once, freeing nursing personnel to perform nursing duties.

Results and Recommendations

QM

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

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

NC	Areas Reviewed	Findings
	There was a senior-level committee/group responsible for QM/performance improvement, and it included the required members.	
	There was evidence that Inpatient Evaluation Center data was discussed by senior managers.	
	Corrective actions from the protected peer review process were reported to the Peer Review Committee.	
X	FPPEs for newly hired licensed independent practitioners complied with selected requirements.	Five profiles reviewed: • Of the five FPPEs initiated, three were not completed.
	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 CPR review policy and processes complied with requirements for reviews of episodes of care where resuscitation was attempted.	Twelve months of CPR Committee meeting minutes reviewed: • There was no evidence that the committee reviewed each code episode.
X	There was an EHR quality review committee, and the review process complied with selected requirements.	Twelve months of EHR Committee meeting minutes reviewed: • There was no evidence that the quality of entries in the EHR was reviewed.
	The EHR copy and paste function was monitored.	

NC	Areas Reviewed (continued)	Findings
X	Appropriate quality control processes were in place for non-VA care documents, and the documents were scanned into EHRs.	Twenty-six EHRs of patients who had non-VA purchased diagnostic tests reviewed: • Eighteen test results were not scanned into the EHRs.
	Use and review of blood/transfusions complied with selected requirements.	
	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 Inpatient Evaluation Center data, utilization management, outcomes from resuscitation, copy and paste, and blood/transfusion reviews.
	There was evidence at the senior leadership level that QM, patient safety, and systems redesign were integrated.	
	Overall, there was evidence that senior managers were involved in performance improvement over the past 12 months.	
	Overall, the facility had a comprehensive, effective QM/performance improvement program over the past 12 months.	
	The facility complied with any additional elements required by VHA or local policy.	

Recommendations

1. We recommended that processes be strengthened to ensure that FPPEs for newly hired licensed independent practitioners are consistently completed.

2. We recommended that processes be strengthened to ensure that the CPR Committee reviews each code episode.

3. We recommended that processes be strengthened to ensure that the quality of entries in the EHR is reviewed.

4. We recommended that processes be strengthened to ensure that the results of non-VA purchased diagnostic tests are consistently scanned into EHRs.

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 Inpatient Evaluation Center data, utilization management, outcomes from resuscitation, copy and paste, and blood/transfusion reviews.

EOC

The purpose of this review was to determine whether the facility maintained a clean and safe health care environment in accordance with applicable requirements.[2]

We inspected the audiology, primary care, women's health, and physical therapy outpatient clinics; the CLC; urgent care; and the medical and mental health inpatient units. Additionally, we reviewed relevant documents, and we interviewed key employees and managers. The table below shows the areas reviewed for this topic. Items that did not apply to this facility are marked "NA." The facility generally met requirements. We made no recommendations.

NC	Areas Reviewed for General EOC	Findings
	EOC Committee minutes reflected sufficient detail regarding identified deficiencies, corrective actions taken, and tracking of corrective actions to closure.	
	An infection prevention risk assessment was conducted, and actions were implemented to address high-risk areas.	
	Infection Prevention/Control Committee minutes documented discussion of identified problem areas and follow-up on implemented actions and included analysis of surveillance activities and data.	
	The facility had a policy that detailed cleaning of equipment between patients.	
	Patient care areas were clean.	
	Fire safety requirements were met.	
	Environmental safety requirements were met.	
	Infection prevention requirements were met.	
	Medication safety and security requirements were met.	
	Sensitive patient information was protected, and patient privacy requirements were met.	
	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.	
	Areas Reviewed for the Women's Health Clinic	
	The Women Veterans Program Manager completed required annual EOC evaluations, and the facility tracked women's health-related deficiencies to closure.	
	Fire safety requirements were met.	
	Environmental safety requirements were met.	
	Infection prevention requirements were met.	
	Medication safety and security requirements were met.	

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

Medication Management – CS Inspections

The purpose of this review was to determine whether the facility complied with requirements related to CS security and inspections.[3]

We reviewed relevant documents and interviewed key employees. We also reviewed the training files of all CS Coordinators and 10 CS inspectors and inspection documentation from 10 CS areas, the inpatient and outpatient pharmacies, and the emergency drug cache. The table below shows the areas reviewed for this topic. The areas marked as NC needed improvement. Items that did not apply to this facility are marked "NA."

NC	Areas Reviewed	Findings
	Facility policy was consistent with VHA requirements.	
	VA police conducted annual physical security surveys of the pharmacy/pharmacies, and any identified deficiencies were corrected.	
	Instructions for inspecting automated dispensing machines were documented, included all required elements, and were followed.	
	Monthly CS inspection findings summaries and quarterly trend reports were provided to the facility Director.	
	CS Coordinator position description(s) or functional statement(s) included duties, and CS Coordinator(s) completed required certification and were free from conflicts of interest.	
	CS inspectors were appointed in writing, completed required certification and training, and were free from conflicts of interest.	
X	Non-pharmacy areas with CS were inspected in accordance with VHA requirements, and inspections included all required elements.	Documentation of 10 CS areas inspected during the past 6 months reviewed: • Two transfers of CS from one storage area to another were not validated.
	Pharmacy CS inspections were conducted in accordance with VHA requirements and included all required elements.	
X	The facility complied with any additional elements required by VHA or local policy.	Facility policies on CS reviewed: • Inspectors did not consistently sign and initial inspection documents in accordance with local policy.

Recommendations

6. We recommended that processes be strengthened to ensure that two transfers of CS from one storage area to another are validated and that compliance be monitored.

7. We recommended that processes be strengthened to ensure that inspectors sign and initial inspection documents in accordance with local policy.

Coordination of Care – HPC

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

We reviewed relevant documents, 20 EHRs of patients who had PCCT consults (including 10 HPC inpatients), and 25 employee training records (10 HPC staff records and 15 non-HPC staff records), and we interviewed key employees. The table below shows the areas reviewed for this topic. The areas marked as NC needed improvement. Items that did not apply to this facility are marked "NA."

NC	Areas Reviewed	Findings
X	A PCCT was in place and had the dedicated staff required.	List of staff assigned to the PCCT reviewed: • An administrative support person had not been dedicated to the PCCT.
	The PCCT actively sought patients appropriate for HPC.	
	The PCCT offered end-of-life training.	
X	HPC staff and selected non-HPC staff had end-of-life training.	• Of the 10 HPC staff, there was no evidence that 2 had end-of-life training. • Of the 15 non-HPC staff, there was no evidence that 9 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.	
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.	
	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.	
X	The facility complied with any additional elements required by VHA or local policy.	• Interdisciplinary care plans for the 10 HPC inpatients lacked elements required by local policy, such as a discussion of code status and advance directives.

Recommendations

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

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

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

11. We recommended that processes be strengthened to ensure that interdisciplinary care plans for HPC inpatients include all elements required by local policy.

Long-Term Home Oxygen Therapy

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

We reviewed relevant documents and 34 EHRs of patients enrolled in the home oxygen program, and we interviewed key employees. The table below shows the areas reviewed for this topic. The areas marked as NC needed improvement. Items that did not apply to this facility are marked "NA."

NC	Areas Reviewed	Findings
	There was a local policy to reduce the fire hazards of smoking associated with oxygen treatment.	
X	The COS reviewed HRCP activities at least quarterly.	• We found no evidence that program activities were reviewed quarterly.
	The facility had established a home respiratory care team.	
	Contracts for oxygen delivery contained all required elements and were monitored quarterly.	
X	Home oxygen program patients had active orders/prescriptions for home oxygen and were re-evaluated for home oxygen therapy annually after the first year.	• There was no documentation that 23 patients (68 percent) were re-evaluated after the first year.
	Patients identified as high risk received hazards education at least every 6 months after initial delivery.	
X	High-risk patients were identified and referred to a multidisciplinary clinical committee for review.	• We found no evidence that patients were being identified as high risk.
X	The facility complied with any additional elements required by VHA or local policy.	• We found no evidence that prescribing clinicians conducted initial and follow-up evaluations of home oxygen program patients as required by VHA and local policy.

Recommendations

12. We recommended that processes be strengthened to ensure that the COS reviews HRCP activities at least quarterly.

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 are identified.

15. We recommended that processes be strengthened to ensure that prescribing clinicians conduct initial and follow-up evaluations of home oxygen program patients.

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 36 training files, and we interviewed key employees. Additionally, we reviewed the actual nursing hours per patient day for acute care unit 30CD and CLC unit 35CD for 50 randomly selected days (holidays, weekdays, and weekend days) between October 1, 2011, and September 30, 2012. The table below shows the areas reviewed for this topic. Items that did not apply to this facility are marked "NA." The facility generally met requirements. We made no recommendations.

NC	Areas Reviewed	Findings
	The unit-based expert panels followed the required processes.	
	The facility expert panel followed the required processes and included all required members.	
	Members of the expert panels completed the required training.	
	The facility completed the required steps to develop a nurse staffing methodology by September 30, 2011.	
	The selected units' actual nursing hours per patient day met or exceeded the target nursing hours per patient day.	
	The facility complied with any additional elements required by VHA or local policy.	

Preventable Pulmonary Embolism

The purpose of this review was to evaluate the care provided to patients who were treated at the facility and developed potentially preventable pulmonary embolism.[7]

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

NC	Areas Reviewed	Findings
X	Patients with potentially preventable pulmonary emboli received appropriate anticoagulation medication prior to the event.	• One patient was identified as having a potentially preventable pulmonary embolism because the patient had risk factors and had not been provided anticoagulation medication.
X	No additional quality of care issues were identified with the patients' care.	• Two patients were identified as having a delayed diagnosis of pulmonary embolism.
	The facility complied with any additional elements required by VHA or local policy/protocols.	

Recommendation

16. We recommended that managers initiate internal protected peer review for the three identified patients and complete any recommended review actions.

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

Facility Profile (Chillicothe/538) FY 2012[b]	
Type of Organization	Secondary
Complexity Level	2-Medium complexity
Affiliated/Non-Affiliated	Affiliated
Total Medical Care Budget in Millions	$197.8
Number of:	
• **Unique Patients**	21,643
• **Outpatient Visits**	329,923
• **Unique Employees[c] (as of last pay period in FY 2012)**	1,419
Type and Number of Operating Beds:	
• **Hospital**	60
• **CLC**	162
• **Domiciliary**	75
Average Daily Census: (through August 2012)	
• **Hospital**	43
• **CLC**	140
• **Domiciliary**	70
Number of Community Based Outpatient Clinics	5
Location(s)/Station Number(s)	Athens/538GA Portsmouth/538GB Marietta/538GC Lancaster/538GD Cambridge/538GE
VISN Number	10

[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	65.8	61.0	53.6	51.1	48.4	54.2
VISN	63.1	64.2	57.1	59.9	59.6	59.2
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	**	10.3	10.4	**	25.3	19.3
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 4, 2013

From: Network Director, VA Healthcare System of Ohio (10N10)

Subject: **CAP Review of the Chillicothe VA Medical Center, Chillicothe, OH**

To: Director, Seattle Office of Healthcare Inspections (54SE)

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

1. I have reviewed the OIG recommendations and concur with Chillicothe VAMC's response submitted by Ms. Wendy J. Hepker, Medical Center Director.

2. If you have questions or require additional information, please contact Ms. Wendy Hepker, Medical Center Director, Chillicothe, VAMC.

(*original signed by:)*
Jack G. Hetrick, FACHE
Network Director, VA Healthcare System of Ohio (10N10)

Facility Director Comments

Department of Veterans Affairs **Memorandum**

Date: February 21, 2013

From: Director, Chillicothe VA Medical Center (538/00)

Subject: **CAP Review of the Chillicothe VA Medical Center, Chillicothe, OH**

To: Director, VA Healthcare System of Ohio (10N10)

Thank you for the opportunity to review the draft report of the Combined Assessment Program (CAP) Review, Chillicothe Veterans Affairs Medical Center. I have reviewed the document and concur with the recommendations.

Corrective action plans have been established with planned completion dates, as detailed in the attached report. If additional information is needed, please contact my office at 740-773-1141

(*original signed by:)*
WENDY J. HEPKER, FACHE
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 FPPEs for newly hired licensed independent practitioners are consistently completed.

Concur

Target date for completion: September 1, 2013

Facility response: The Medical Center strengthened the process to ensure that FPPEs for newly hired licensed independent practitioners are consistently completed. The process was implemented on February 1, 2013. Compliance with completing the FPPE on or before the due date will be monitored for six months. The percentage of compliance will be reported monthly to the Medical Staff Executive Committee (MSEC) Credentials Subcommittee and to MSEC.

Recommendation 2. We recommended that processes be strengthened to ensure that the CPR Committee reviews each code episode.

Concur

Target date for completion: January 1, 2014

Facility response: The Medical Center strengthened the process to ensure that the CPR Committee reviews each code. The process has been revised and implemented to include that each Code Blue report, along with the Code Blue Debriefing record, will be brought to the CPR Committee meetings for review by the committee. Discussion and actions will be documented in the CPR Committee meeting minutes. CPR committee minutes will be monitored for three quarters to ensure compliance.

Recommendation 3. We recommended that processes be strengthened to ensure that the quality of entries in the EHR is reviewed.

Concur

Target date for completion: January 1, 2014

Facility response: The Medical Center strengthened the process to ensure that the quality of entries in the EHR is reviewed. A Peer-to-Peer, Clinician Quality Review form has been developed for the providers to assess the quality of EHR entries. Results from the reviews will be aggregated and reported to the Medical Records Committee quarterly. Discussions and actions will be documented in the Medical Records

Committee meeting minutes. Meeting minutes will be monitored for three quarters to ensure compliance.

Recommendation 4. We recommended that processes be strengthened to ensure that the results of non-VA purchased diagnostic tests are consistently scanned into EHRs.

Concur

Target date for completion: January 1, 2014

Facility response: The Medical Center has implemented a strengthened process to assure that unauthorized emergent non-VA purchased care results will be scanned into the electronic health record. Compliance will be monitored quarterly for three quarters and reported to the Medical Records Committee. Any barriers to success will be identified and adjustments to the process will be made.

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 Inpatient Evaluation Center data, utilization management, outcomes from resuscitation, copy and paste, and blood/transfusion reviews.

Concur

Target date for completion: September 1, 2013

Facility response: The Medical Center implemented a strengthened process to ensure that corrective actions identified in committee meetings are documented and followed to resolution. All committee chairpersons and/or their representatives will attend a class on committee documentation. The Medical Center Governance Policy is currently being updated and will incorporate a monthly review of this strengthened process and will be reported to the Leadership Council for a period six months.

Recommendation 6. We recommended that processes be strengthened to ensure that two transfers of CS from one storage area to another are validated and that compliance be monitored.

Concur

Target date for completion: September 1, 2013

Facility response: The process for validating transfers of CS from one area to another has been revised and communicated to all Controlled Substance Inspectors. Compliance with this strengthened process will be monitored by the Controlled Substance Coordinator and/or alternate and reported monthly to the Medical Center Director for a period of six months.

Recommendation 7. We recommended that processes be strengthened to ensure that inspectors sign and initial inspection documents in accordance with local policy.

Concur

Target date for completion: September 1, 2013

Facility response: As of February 6, 2013, the guidance and expectations regarding signatures and initials on inspections was revised and distributed to all Controlled Substance Inspectors (CSI). Compliance of this strengthened process will be monitored by the Controlled Substance Coordinator and/or alternate and reported monthly to the Medical Center Director for a period of six months.

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

Concur

Target date for completion: July 31, 2013

Facility response: The Geriatric Extended Care Line (GECL) is revising a position to include a .25 dedication to provide administrative support to the palliative care/hospice (PCCT) program.

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

Concur

Target date for completion: September 1, 2013

Facility response: The Medical Center has made it a priority to make Basic End of Life Care education available to all staff. All Hospice and Palliative Care staff is required to complete this training. All other staff will have the training available and participation will be encouraged and supported. The education modules are available in the Talent Management System (TMS). Progress of this strengthened process will be monitored by the GECL Clinical Educator and reported to the GECL meeting monthly for a period of six months.

Recommendation 10. 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: September 1, 2013

Facility response: As of January 30, 2013 a new process was designed and implemented to ensure bereavement services are offered to all CLC-based hospice residents and families. Compliance with this strengthened process will be monitored by the Palliative Care Team Coordinator and reported to the GECL meeting on a monthly basis for six months.

Recommendation 11. We recommended that processes be strengthened to ensure that interdisciplinary care plans for HPC inpatients include all elements required by local policy.

Concur

Target date for completion: September 1, 2013

Facility response: A process has been developed for all Hospice and Palliative Care staff to receive education on the requirements of the Hospice and Palliative Care plan. Compliance with this strengthened process will be monitored and reported monthly to the Geriatrics and Extended Care Quality meeting for six months.

Recommendation 12. We recommended that processes be strengthened to ensure that the COS reviews HRCP activities at least quarterly.

Concur

Target date for completion: January 1, 2014

Facility response: The Home Oxygen program will report quarterly to the Medical Staff Executive Committee (MSEC), of which the Chief of Staff is chairperson. The MSEC minutes will be monitored for three quarters to ensure the Home Oxygen Program reports will be reflected in the MSEC minutes.

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: September 1, 2013

Facility response: A process has been developed to track when Veterans are due for the required follow-up using a recall system and an electronic database. Compliance with this strengthened process will be monitored and reported to the Home Oxygen Oversight Committee monthly for a period of six months, and when the committee is due to report, to the Medical Service Executive Committee (MSEC).

Recommendation 14. We recommended that processes be strengthened to ensure that high-risk home oxygen patients are identified.

Concur

Target date for completion: September 1, 2013

Facility response: The Medical Center is designing a strengthened process to ensure that all high-risk home oxygen patients will be identified in the EHR and the electronic database. Compliance with this process will be monitored and reported to the Home Oxygen Oversight Committee monthly for a period of six months, and when the committee is due to report, to the Medical Service Executive Committee (MSEC).

Recommendation 15. We recommended that processes be strengthened to ensure that prescribing clinicians conduct initial and follow-up evaluations of home oxygen program patients.

Concur

Target date for completion: September 1, 2013

Facility response: The Medical Center has designed a strengthened process to ensure that a prescribing clinician conducts the initial and follow-up evaluations of the Home Oxygen Program patients. All follow-ups will be monitored for compliance with this process for six months and reported to the Home Oxygen Oversight Committee, and when the committee is due to report, to MSEC.

Recommendation 16. We recommended that managers initiate internal protected peer review for the three identified patients and complete any recommended review actions.

Concur

Target date for completion: April 30, 2013

Facility response: The Chief of Staff reviewed the three identified patients and initialized internal protected peer reviews which have been completed. All three reviews have been scheduled for a secondary review as of February 19, 2013. Upon completion of the review, results will be evaluated by the Peer Review Committee. Any recommended actions will be followed to completion.

OIG Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the OIG at (202) 461-4720.
Contributors	Susan Tostenrude, MS, Team Leader Sarah Lutter, RN, JD Karen A. Moore, RNC, MSHA Sami O'Neill, MA Noel Rees, MPA Marc Lainhart, BS, Management and Program Analyst

Report Distribution

VA Distribution

Office of the Secretary
Veterans Health Administration
Assistant Secretaries
General Counsel
Director, VA Healthcare System of Ohio (10N10)
Director, Chillicothe VA Medical Center (538/00)

Non-VA Distribution

House Committee on Veterans' Affairs
House Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
House Committee on Oversight and Government Reform
Senate Committee on Veterans' Affairs
Senate Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
Senate Committee on Homeland Security and Governmental Affairs
National Veterans Service Organizations
Government Accountability Office
Office of Management and Budget
U.S. Senate: Sherrod Brown, Rob Portman
U.S. House of Representatives: Bill Johnson, Steve Stivers, Michael Turner, Brad Wenstrup

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

Endnotes

[1] References used for this topic included:
- VHA Directive 2009-043, *Quality Management System*, September 11, 2009.
- VHA Handbook 1050.01, *VHA National Patient Safety Improvement Handbook*, March 4, 2011.
- VHA Directive 2010-017, *Prevention of Retained Surgical Items*, April 12, 2010.
- VHA Directive 2010-025, *Peer Review for Quality Management*, June 3, 2010.
- VHA Directive 2010-011, *Standards for Emergency Departments, Urgent Care Clinics, and Facility Observation Beds*, March 4, 2010.
- VHA Directive 2009-064, *Recording Observation Patients*, November 30, 2009.
- VHA Handbook 1100.19, *Credentialing and Privileging*, November 14, 2008.
- VHA Directive 2008-063, *Oversight and Monitoring of Cardiopulmonary Resuscitative Events and Facility Cardiopulmonary Resuscitation Committees*, October 17, 2008.
- VHA Handbook 1907.01, *Health Information Management and Health Records*, September 19, 2012.
- VHA Directive 6300, Records Management, July 10, 2012.
- VHA Directive 2009-005, *Transfusion Utilization Committee and Program*, February 9, 2009.
- VHA Handbook 1106.01, *Pathology and Laboratory Medicine Service Procedures*, October 6, 2008.
- VHA Directive 2008-007, *Resident Assessment Instrument (RAI) Minimum Data Set (MDS)*, February 4, 2008; 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:
- VHA Directive 2011-007, *Required Hand Hygiene Practices*, February 16, 2011.
- VHA Handbook 1330.01, *Health Care Services for Women Veterans*, May 21, 2010.
- VA National Center for Patient Safety, "Ceiling mounted patient lift installations," Patient Safety Alert 10-07, March 22, 2010.
- Various requirements of The Joint Commission, the Centers for Disease Control and Prevention, the Occupational Safety and Health Administration, the National Fire Protection Association, the American National Standards Institute, the Association for the Advancement of Medical Instrumentation, and the International Association of Healthcare Central Service Material Management.

[3] References used for this topic included:
- VHA Handbook 1108.01, *Controlled Substances (Pharmacy Stock)*, November 16, 2010.
- VHA Handbook 1108.02, *Inspection of Controlled Substances*, March 31, 2010.
- VHA Handbook 1108.05, *Outpatient Pharmacy Services*, May 30, 2006.
- VHA Handbook 1108.06, *Inpatient Pharmacy Services*, June 27, 2006.
- VHA, "Clarification of Procedures for Reporting Controlled Substance Medication Loss as Found in VHA Handbook 1108.01," Information Letter 10-2011-004, April 12, 2011.
- VA Handbook 0730, *Security and Law Enforcement*, August 11, 2000.
- VA Handbook 0730/2, *Security and Law Enforcement*, May 27, 2010.

[4] References used for this topic included:
- VHA Directive 2008-066, *Palliative Care Consult Teams (PCCT)*, October 23, 2008.
- 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.