Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 13-00277-134

Combined Assessment Program Review of the Central Arkansas Veterans Healthcare System Little Rock, Arkansas

March 15, 2013

Washington, DC 20420

To Report Suspected Wrongdoing in VA Programs and Operations
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Glossary

CAP	Combined Assessment Program
CLC	community living center
CS	controlled substances
EHR	electronic health record
EOC	environment of care
facility	Central Arkansas Veterans Healthcare System
FPPE	Focused Professional Practice Evaluation
FY	fiscal year
HPC	hospice and palliative care
NA	not applicable
NC	noncompliant
OIG	Office of Inspector General
PCCT	Palliative Care Consult Team
PM&R	physical medicine and rehabilitation
QM	quality management
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

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Executive Summary

Review Purpose: The purpose of the review was to evaluate selected health care facility operations, focusing on patient care quality and the environment of care, and to provide crime awareness briefings. We conducted the review the week of January 28, 2013.

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

- Medication Management – Controlled Substances Inspections
- Coordination of Care – Hospice and Palliative Care
- Long-Term Home Oxygen Therapy

The facility's reported accomplishments were the Palliative Care Program and the Nursing Evidence-Based Practice Scholar Program.

Recommendations: We made recommendations in the following four activities:

Quality Management: Consistently report the results of Focused Professional Practice Evaluations for newly hired licensed independent practitioners to the Medical Executive Board. Consistently perform continued stay reviews on at least 75 percent of patients in acute beds.

Environment of Care: Ensure patient care areas are clean, and monitor compliance. Maintain the facility, and monitor compliance. Repair or remove damaged furniture in patient care areas. Correctly date all multi-dose medication vials when opened. Maintain patient privacy in the physical medicine and rehabilitation clinic during potentially exposing treatment modalities.

Nurse Staffing: Include all required staff on both the facility and unit-based expert panels.

Preventable Pulmonary Embolism: Initiate protected peer review for the two 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 14–18, 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 28, 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 Central Arkansas Veterans Healthcare System, Little Rock, Arkansas,* Report No. 11-01296-235, August 2, 2011).

During this review, we presented crime awareness briefings for 227 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 212 responded. We shared survey results with facility managers.

In this report, we make recommendations for improvement. Recommendations pertain to issues that are significant enough to be monitored by the OIG until corrective actions are implemented.

Reported Accomplishments

Palliative Care Program

The Palliative Care Team promotes early education programs for end-of-life care at many levels. The team continues to work in partnership with the Arkansas Chapter of the National Gerontological Nursing Association, the University of Arkansas for Medical Sciences College of Nursing, the Little Rock Oncology Nursing Network, and community hospice partners throughout the state to present education programs. Additionally, a physician on the team developed and implemented the first Hospice and Palliative Medicine Fellowship Program in the state. Seven physicians have completed the 1-year fellowship and are now board certified in palliative care medicine or eligible for certification. Furthermore, this year the 1-year Pharmacy Residency Program developed by the palliative care pharmacist began. Also, since 2011, the facility has been a sponsor of an annual statewide palliative care conference, which brings in multidisciplinary attendees from across the United States.

Nursing Evidence-Based Practice Scholar Program

In 2010, Nursing Service initiated an evidence-based practice scholar program designed to allow direct care registered nurses dedicated time to focus on evidence-based initiatives to improve their area. The facility's successes led VISN 16 to implement a VISN-wide program in 2012.

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.	Thirteen profiles reviewed: • Of the 12 FPPEs completed, results of 2 were not reported to the Medical Executive Board.
	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.	
X	Staff performed continuing stay reviews on at least 75 percent of patients in acute beds.	Eleven months of continuing stay data reviewed: • For all 11 months, less than 75 percent of acute inpatients were reviewed.
	Appropriate processes were in place to prevent incidents of surgical items being retained in a patient following surgery.	
	The cardiopulmonary resuscitation review policy and processes complied with requirements for reviews of episodes of care where resuscitation was attempted.	
	There was an EHR quality review committee, and the review process complied with selected requirements.	
	The EHR copy and paste function was monitored.	

	Appropriate quality control processes were in place for non-VA care documents, and the documents were scanned into EHRs.	
	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.	
	Overall, if significant issues were identified, actions were taken and evaluated for effectiveness.	
	There was evidence at the senior leadership level that QM, patient safety, and systems redesign were integrated.	
	Overall, there was evidence that senior managers were involved in performance improvement over the past 12 months.	
	Overall, the facility had a comprehensive, effective QM/performance improvement program over the past 12 months.	
	The facility complied with any additional elements required by VHA or local policy.	

Recommendations

1. We recommended that processes be strengthened to ensure that results of FPPEs for newly hired licensed independent practitioners are consistently reported to the Medical Executive Board.

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

EOC

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

At the Little Rock division, we inspected a medical, a surgical, and an intensive care unit; the emergency department; the women's health clinic; and two PM&R therapy clinics. At the North Little Rock division, we inspected a mental health inpatient unit, two CLC units, and two PM&R therapy clinics. Additionally, we reviewed relevant documents and interviewed key employees and managers. The table below shows the areas reviewed for this topic. The areas marked as NC needed improvement. Items that did not apply to this facility are marked "NA."

NC	Areas Reviewed for General EOC	Findings
	EOC Committee minutes reflected sufficient detail regarding identified deficiencies, corrective actions taken, and tracking of corrective actions to closure.	
	An infection prevention risk assessment was conducted, and actions were implemented to address high-risk areas.	
	Infection Prevention/Control Committee minutes documented discussion of identified problem areas and follow-up on implemented actions and included analysis of surveillance activities and data.	
	The facility had a policy that detailed cleaning of equipment between patients.	
X	Patient care areas were clean.	• Six of the seven units/areas inspected were not clean.
	Fire safety requirements were met.	
X	Environmental safety requirements were met.	• We found damaged furniture, walls, floors, doors, or doorframes in six of the seven units/areas inspected.
	Infection prevention requirements were met.	
X	Medication safety and security requirements were met.	• On two units, opened multi-dose medication vials were either not dated or not dated correctly so that staff would know when they would expire.
	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.	

NC	Areas Reviewed for the Women's Health Clinic (continued)	Findings
	Fire safety requirements were met.	
X	Environmental safety requirements were met.	• We found wall penetrations and damaged doorframes in the clinic.
	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 PM&R Therapy Clinics	
	Fire safety requirements were met.	
	Environmental safety requirements were met.	
	Infection prevention requirements were met.	
	Medication safety and security requirements were met.	
X	Patient privacy requirements were met.	• Employees in the PM&R clinic did not consistently maintain patient privacy during exposing treatments.
	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.	

Recommendations

3. We recommended that processes be strengthened to ensure that patient care areas are clean and that compliance be monitored.

4. We recommended that processes be strengthened to ensure that the facility is well maintained and that compliance be monitored and that damaged furniture in patient care areas be repaired or removed from service.

5. We recommended that processes be strengthened to ensure that multi-dose medication vials are dated correctly when opened.

6. We recommended that processes be strengthened to ensure that patient privacy is maintained in the PM&R clinic during potentially exposing treatment modalities.

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. Items that did not apply to this facility are marked "NA." The facility generally met requirements. We made no recommendations.

NC	Areas Reviewed	Findings
	Facility policy was consistent with VHA requirements.	
	VA police conducted annual physical security surveys of the pharmacy/pharmacies, and any identified deficiencies were corrected.	
	Instructions for inspecting automated dispensing machines were documented, included all required elements, and were followed.	
	Monthly CS inspection findings summaries and quarterly trend reports were provided to the facility Director.	
	CS Coordinator position description(s) or functional statement(s) included duties, and CS Coordinator(s) completed required certification and were free from conflicts of interest.	
	CS inspectors were appointed in writing, completed required certification and training, and were free from conflicts of interest.	
	Non-pharmacy areas with CS were inspected in accordance with VHA requirements, and inspections included all required elements.	
	Pharmacy CS inspections were conducted in accordance with VHA requirements and included all required elements.	
	The facility complied with any additional elements required by VHA or local policy.	

Coordination of Care – HPC

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

We reviewed relevant documents, 20 EHRs of patients who had PCCT consults (including 10 HPC inpatients), and 25 employee training records (10 HPC staff records and 15 non-HPC staff records), and we interviewed key employees. The table below shows the areas reviewed for this topic. Items that did not apply to this facility are marked "NA." The facility generally met requirements. We made no recommendations.

NC	Areas Reviewed	Findings
	A PCCT was in place and had the dedicated staff required.	
	The PCCT actively sought patients appropriate for HPC.	
	The PCCT offered end-of-life training.	
	HPC staff and selected non-HPC staff had end-of-life training.	
	The facility had a VA liaison with community hospice programs.	
	The PCCT promoted patient choice of location for hospice care.	
	The CLC-based hospice program offered bereavement services.	
	The HPC consult contained the word "palliative" or "hospice" in the title.	
	HPC consults were submitted through the Computerized Patient Record System.	
	The PCCT responded to consults within the required timeframe and tracked consults that had not been acted upon.	
	Consult responses were attached to HPC consult requests.	
	The facility submitted the required electronic data for HPC through the VHA Support Service Center.	
	An interdisciplinary team care plan was completed for HPC inpatients within the facility's specified timeframe.	
	HPC inpatients were assessed for pain with the frequency required by local policy.	
	HPC inpatients' pain was managed according to the interventions included in the care plan.	
	HPC inpatients were screened for an advanced directive upon admission and according to local policy.	
	The facility complied with any additional elements required by VHA or local policy.	

Long-Term Home Oxygen Therapy

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

We reviewed relevant documents and 35 EHRs of patients enrolled in the home oxygen program (including 13 patients deemed to be high risk), and we interviewed key employees. The table below shows the areas reviewed for this topic. Items that did not apply to this facility are marked "NA." The facility generally met requirements. We made no recommendations.

NC	Areas Reviewed	Findings
	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.	
	Home oxygen program patients had active orders/prescriptions for home oxygen and were re-evaluated for home oxygen therapy annually after the first year.	
	Patients identified as high risk received hazards education at least every 6 months after initial delivery.	
	NC high-risk patients were identified and referred to a multidisciplinary clinical committee for review.	
	The facility complied with any additional elements required by VHA or local policy.	

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 24 training files, and we interviewed key employees. Additionally, we reviewed the actual nursing hours per patient day for acute care unit 6D and CLC unit 1B 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. The areas marked as NC needed improvement. Items that did not apply to this facility are marked "NA."

NC	Areas Reviewed	Findings
X	The unit-based expert panels followed the required processes.	• Unit 1B's panel did not include licensed practical nurses and nursing assistants.
X	The facility expert panel followed the required processes and included all required members.	• The facility panel did not include other nursing staff providing direct patient care and nurse managers from the various areas of the facility.
	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.	

Recommendation

7. We recommended that the annual staffing plan reassessment process ensures that all required staff are facility and unit-based expert panel members.

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

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

Recommendation

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

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

Facility Profile (Little Rock/598) FY 2012[b]	
Type of Organization	Tertiary
Complexity Level	1b-High complexity
Affiliated/Non-Affiliated	Affiliated
Total Medical Care Budget in Millions	$545.0
Number of:	
• **Unique Patients**	88,845
• **Outpatient Visits**	807,148
• **Unique Employees[c] (as of last pay period in FY 2012)**	2,744
Type and Number of Operating Beds:	
• **Hospital**	255
• **CLC**	152
• **Mental Health**	119
Average Daily Census: (through August 2012)	
• **Hospital**	202
• **CLC**	111
• **Mental Health**	104
Number of Community Based Outpatient Clinics	8
Location(s)/Station Number(s)	Mountain Home/598GA Eldorado/598GB Hot Springs/598GC Mena/598GD Pine Bluff/598GE Searcy/598GF Conway/598GG Russellville/598GH
VISN Number	16

[b] All data is for FY 2012 except where noted.
[c] Unique employees involved in direct medical care (cost center 8200).

VHA Patient Satisfaction Survey

VHA has identified patient satisfaction scores as significant indicators of facility performance. Patients are surveyed monthly. Table 1 below shows facility, VISN, and VHA overall inpatient satisfaction scores for quarters 3–4 of FY 2011 and quarters 1–2 of FY 2012 and outpatient satisfaction scores for quarter 4 of FY 2011 and quarters 1–3 of FY 2012.

Table 1

	Inpatient Scores		Outpatient Scores			
	FY 2011	FY 2012	FY 2011	FY 2012		
	Inpatient Score Quarters 3–4	Inpatient Score Quarters 1–2	Outpatient Score Quarter 4	Outpatient Score Quarter 1	Outpatient Score Quarter 2	Outpatient Score Quarter 3
Facility	65.6	61.9	48.7	54.9	50.5	49.5
VISN	65.9	64.1	50.7	52.3	50.9	50.6
VHA	64.1	63.9	54.5	55.0	54.7	54.3

Hospital Outcome of Care Measures

Hospital Outcome of Care Measures show what happened after patients with certain conditions received hospital care.[d] Mortality (or death) rates focus on whether patients died within 30 days of being hospitalized. Readmission rates focus on whether patients were hospitalized again within 30 days of their discharge. These rates are based on people who are 65 and older and are "risk-adjusted" to take into account how sick patients were when they were initially admitted. Table 2 below shows facility and U.S. national Hospital Outcome of Care Measure rates for patients discharged between July 1, 2008, and June 30, 2011.[e]

Table 2

	Mortality			Readmission		
	Heart Attack	Heart Failure	Pneumonia	Heart Attack	Heart Failure	Pneumonia
Facility	14.5	9.0	12.1	20.1	27.5	23.3
U.S. National	15.5	11.6	12.0	19.7	24.7	18.5

[d] A heart attack occurs when blood flow to a section of the heart muscle becomes blocked, and the blood supply is slowed or stopped. If the blood flow is not restored timely, the heart muscle becomes damaged. Heart failure is a weakening of the heart's pumping power. Pneumonia is a serious lung infection that fills the lungs with mucus and causes difficulty breathing, fever, cough, and fatigue.

[e] Rates were calculated from Medicare data and do not include data on people in Medicare Advantage Plans (such as health maintenance or preferred provider organizations) or people who do not have Medicare.

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: February 28, 2013

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

Subject: **CAP Review of the Central Arkansas Veterans Healthcare System, Little Rock, AR**

To: Director, Dallas Office of Healthcare Inspections (54DA)

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

I concur with the recommendations presented in the OIG CAP review for the Central Arkansas Veterans Healthcare System.

(original signed by:)
Rica Lewis-Payton, MHA, FACHE
Director, South Central VA Health Care Network (10N16)

Appendix D

Facility Director Comments

Department of Veterans Affairs **Memorandum**

Date: February 21, 2013

From: Director, Central Arkansas Veterans Healthcare System (598/00)

Subject: **CAP Review of the Central Arkansas Veterans Healthcare System, Little Rock, AR**

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

I concur with the recommendations presented in the OIG CAP review of the Central Arkansas Veterans Healthcare System. Actions taken as a result of the recommendations can be found in the following pages.

(original signed by:)
Michael R. Winn
Director, Central Arkansas Veterans Healthcare System (598/00)

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 results of FPPEs for newly hired licensed independent practitioners are consistently reported to the Medical Executive Board.

Concur

Target date for completion: 2/19/2013

Facility response: Credentialing and Privileging coordinator has established a Professional Standards Committee (PSC) pre-meeting in which the Chief of Staff (COS) and Service Chiefs review upcoming Focused Professional Practice Evaluation (FPPE) packets scheduled for action at the next Medical Executive Board (MEB) meeting. PSC pre-meetings were initiated 2/6/2013 prior to the 2/19/2013 MEB meeting. This process facilitates consistent reporting and close-out of FPPE reporting to the MEB.

Recommendation 2. We recommended that processes be strengthened to ensure that continued stay reviews are consistently performed on at least 75 percent of patients in acute beds.

Concur

Target date for completion: 2/1/2013

Facility response: We have established 12 hour tours to facilitate uploading information to NUMI. The COS Administrative Officer continues to monitor NUMI data for admissions and continued stays daily by reviewer, and reports this to Leadership weekly. In January 2013 the level of compliance was 77.6%. February to date is on target to exceed the goal.

Recommendation 3. We recommended that processes be strengthened to ensure that patient care areas are clean and that compliance be monitored.

Concur

Target date for completion: 4/1/2013

Facility response: 1. EMS Leadership (Chief, Assistant Chief, Supervisory Environmental Care Specialists, and Supervisors), will increase random focused tracers of areas for compliance with cleanliness and removing or repairing furnishings. EMS

Leadership will document these checks and provide feedback to employees regarding findings.

2. Findings of the random checks will be expressed numerically as a percentage of compliance and will be reported monthly through the Executive Safety Committee; a compliance rate of above 90% is target.

3. Facility Leadership will continue to support and provide timely approval to fill vacancies in this high turn-over occupation.

Recommendation 4. We recommended that processes be strengthened to ensure that the facility is well maintained and that compliance be monitored and that damaged furniture in patient care areas be repaired or removed from service.

Concur

Target date for completion: 4/1/2013

Facility response: 1. Facility staff to enter all identified deficiencies into the appropriate environmental management replacement system.

2. Chief of Environmental Management Service will assure that requests for replacement or repair of furnishing are completed per policy.

3. Monitoring will be accomplished by the Environmental Assessment Team and reported through Executive Safety Committee monthly, a compliance rate of above 90% is target.

Recommendation 5. We recommended that processes be strengthened to ensure that multi-dose medication vials are dated correctly when opened.

Concur

Target date for completion: 3/1/2013

Facility response: Nursing Service will monitor a total of 30 multi dose vials for expiration date labeling per month on all inpatient and extended care units/neighborhoods as per policy. Nursing Performance Improvement Coordinators will conduct monitoring beginning 3/1/2013 and continuing until five months of 90% or greater compliance is achieved.

Recommendation 6. We recommended that processes be strengthened to ensure that patient privacy is maintained in the PM&R clinic during potentially exposing treatment modalities.

Concur

Target date for completion: 2/14/2013

Facility response: Initial education concerning visual maintenance of privacy, especially during treatments has been conducted with PM&RS staff. This included the importance of ensuring that patients will be appropriately gowned and/or draped when receiving treatment.

Recommendation 7. We recommended that the annual staffing plan reassessment process ensures that all required staff are facility and unit-based expert panel members.

Concur

Target date for completion: 2/25/2013

Facility response: Composition of unit based and facility expert panels will include all levels of staff as appropriate, including their names and titles. The annual report will contain a listing of each facility level expert panel member, level of staff and area represented. Unit Level Staffing Methodology reports will ensure all levels of staff are included in the analysis and recommendations.

Recommendation 8. We recommended that managers initiate protected peer review for the two identified patients and complete any recommended review actions.

Concur

Target date for completion: 1/23/2013

Facility response: Peer reviews have been initiated on the two identified patients. If the Peer Review Committee makes final determination on any recommended actions on systems processes, those will be completed.

OIG Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the OIG at (202) 461-4720.
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Office of Management and Budget
U.S. Senate: John Boozman, Mark L. Pryor
U.S. House of Representatives: Tom Cotton, Rick Crawford, Tim Griffin, Steve Womack

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:
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