Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 13-00279-156

Combined Assessment Program Review of the VA Palo Alto Health Care System Palo Alto, California

March 28, 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
EOC	environment of care
facility	VA Palo Alto Health Care 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
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:

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

The facility's reported accomplishments were a performance excellence award, a patient safety culture collaborative, and an extensive research program.

Recommendations: We made recommendations in the following four activities:

Quality Management: Ensure actions from peer reviews are clearly defined and consistently tracked to completion at the service level. Consistently complete Focused Professional Practice Evaluations for newly hired licensed independent practitioners. Ensure the results of proficiency testing and the results of peer reviews when transfusions did not meet criteria are reported to the Transfusion Review Committee.

Environment of Care: Ensure Environment of Care Committee minutes reflect that actions taken in response to identified deficiencies are tracked to closure. Require that sharps containers in the Menlo Park community living center are readily accessible to staff, that medication carts are secured at all times, and that expired multi-dose vials are removed from community living center medication carts.

Nurse Staffing: Fully implement the nurse staffing methodology.

Preventable Pulmonary Embolism: Initiate protected peer review for the one identified patient, 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 consider recommendations 5 and 9 closed. We will follow up on the planned actions for the open recommendations until they are completed.

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

Objectives and Scope

Objectives

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

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

Scope

We reviewed selected clinical and administrative activities to evaluate compliance with requirements related to patient care quality and the EOC. In performing the review, we inspected selected areas, interviewed managers and employees, and reviewed clinical and administrative records. The review covered the following 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 2012 and FY 2013 through January 31, 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 VA Palo Alto Health Care System, Palo Alto, California,* Report No. 11-00028-140, April 4, 2011).

During this review, we presented crime awareness briefings for 389 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 344 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

Award for Excellence

The facility received a 2012 Silver-level California Awards for Performance Excellence Eureka Award from the California Council for Excellence. The award program, which emulates the Malcolm Baldrige National Quality Award,[a] recognizes organizations that demonstrate superior performance in seven key business areas—leadership; strategic planning; customer and market focus; measurement, analysis, and knowledge management; workforce focus; process management; and results.

Joint Commission Collaborative

In early 2012, the facility participated in an 18-month patient safety culture collaborative with The Joint Commission. Seven health care systems throughout the country participated in this collaborative, and the facility was the only VA health care system involved. In December 2012, the facility implemented safety huddles, which are brief daily meetings, in the medical/surgical intensive care unit. The intent of the safety huddles is to teach and foster staff understanding of improvement methods within their daily duties.

Extensive Research Program

The facility has the second largest research program in VA. With approximately $55 million in research funding, the facility supports extensive research programs in geriatrics, mental health, Alzheimer's disease, spinal cord injury, rehabilitation, human immunodeficiency virus, and health economics. The facility participates in many clinical trials both through VA's Cooperative Studies Program and industry sponsored research. Affiliated with Stanford University, the facility has approximately 180 principal investigators who are engaged in more than 500 research projects at any given time. Facility investigators continue to be the recipients of numerous prestigious national and international awards.

[a] The Malcolm Baldrige National Quality Award is presented by the U.S. Department of Commerce to promote and enhance best practices within an organization.

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.	
X	Corrective actions from the protected peer review process were reported to the Peer Review Committee.	Nine months of Peer Review Committee meeting minutes reviewed: • Of 17 actions expected to be completed, 12 were not adequately defined and were not tracked to completion at the service level.
X	FPPEs for newly hired licensed independent practitioners complied with selected requirements.	Twenty-five profiles reviewed: • Fourteen FPPEs 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.	
	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.	

NC	Areas Reviewed (continued)	Findings
	The EHR copy and paste function was monitored.	
	Appropriate quality control processes were in place for non-VA care documents, and the documents were scanned into EHRs.	
X	Use and review of blood/transfusions complied with selected requirements.	Four quarters of the Transfusion Committee meeting minutes reviewed: • The results of proficiency testing and the results of peer reviews when transfusions did not meet criteria were not reported to the committee.
	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 actions from peer reviews are clearly defined and consistently tracked to completion at the service level.

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

3. We recommended that processes be strengthened to ensure that the results of proficiency testing and the results of peer reviews when transfusions did not meet criteria are reported to the Transfusion Review Committee.

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 (two medical/surgical, one hospice, two intensive care, one locked mental health, and one spinal cord injury). We also inspected the CLC (five units), the emergency department, the women's health clinic, outpatient surgery, and two physical medicine and rehabilitation 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
X	EOC Committee minutes reflected sufficient detail regarding identified deficiencies, corrective actions taken, and tracking of corrective actions to closure.	Six months of EOC Committee meeting minutes reviewed: • Minutes did not reflect that actions were tracked 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.	
X	Infection prevention requirements were met.	• Sharps containers in the Menlo Park CLC were mounted at heights and/or in locations that were not readily accessible to all staff.
X	Medication safety and security requirements were met.	• There were unlocked medication carts in two of the 12 units/areas inspected. • There were expired multi-dose vials in medication carts on two of the five CLC units.
	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.	

	Areas Reviewed for the Women's Health Clinic (continued)	
	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.	
NA	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

4. We recommended that processes be strengthened to ensure that EOC Committee minutes reflect that actions taken in response to identified deficiencies are tracked to closure.

5. We recommended that processes be strengthened to ensure that sharps containers in the Menlo Park CLC are readily accessible to all staff.

6. We recommended that processes be strengthened to ensure that medication carts are secured at all times and that compliance be monitored.

7. We recommended that processes be strengthened to ensure that expired multi-dose vials are removed from medication carts in the CLC.

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 the CS Coordinator, the Alternate CS Coordinator, and 10 CS inspectors and inspection documentation from 12 CS areas, the pharmacies at all three divisions, 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, 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 we interviewed key employees. The table below shows the areas reviewed for this topic. The area marked as NC needed improvement. Items that did not apply to this facility are marked "NA."

NC	Areas Reviewed	Findings
	The unit-based expert panels followed the required processes.	
	The facility expert panel followed the required processes and included all required members.	
	Members of the expert panels completed the required training.	
X	The facility completed the required steps to develop a nurse staffing methodology by September 30, 2011.	• The facility had not fully implemented the staffing methodology.
	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

8. We recommended that the facility fully implement the nurse staffing methodology.

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

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

Recommendation

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

[b] 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 (Palo Alto/640) FY 2012[c]	
Type of Organization	Tertiary
Complexity Level	1a-High complexity
Affiliated/Non-Affiliated	Affiliated
Total Medical Care Budget in Millions (through August 2012)	$832.6
Number of:	
• **Unique Patients**	64,885
• **Outpatient Visits**	756,868
• **Unique Employees[d] (as of last pay period in FY 2012)**	3,686
Type and Number of Operating Beds:	
• **Hospital**	266
• **CLC**	360
• **Mental Health**	172
Average Daily Census: (through August 2012)	
• **Hospital**	185
• **CLC**	272
• **Mental Health**	123
Number of Community Based Outpatient Clinics	7
Location(s)/Station Number(s)	San Jose/640BY Capitola/640GA Sonora/640GB Fremont/640GC Stockton/640HA Modesto/640HB Monterey/640HC
VISN Number	21

[c] All data is for FY 2012 except where noted.
[d] 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	74.9	75.1	63.4	64.6	64.9	59.7
VISN	70.0	70.1	57.4	58.1	55.8	57.4
VHA	64.1	63.9	54.5	55.0	54.7	54.3

Hospital Outcome of Care Measures

Hospital Outcome of Care Measures show what happened after patients with certain conditions received hospital care.[e] 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.[f]

Table 2

	Mortality			Readmission		
	Heart Attack	Heart Failure	Pneumonia	Heart Attack	Heart Failure	Pneumonia
Facility	15.1	9.2	12.7	18.5	23.9	20.5
U.S. National	15.5	11.6	12.0	19.7	24.7	18.5

[e] 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.

[f] 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 8, 2013

From: Director, Sierra Pacific Network (10N21)

Subject: **CAP Review of the VA Palo Alto Health Care System, Palo Alto, CA**

To: Director, Los Angeles Office of Healthcare Inspections (54LA)

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

1. Palo Alto has developed the attached action plan in response to the OIG CAP review that occurred this past January.

2. The action plan developed should ensure full compliance with the requirements and meet the recommendations.

3. Should you have any questions, please contact Terry Sanders, Associate Quality Manager for VISN 21 at (707) 562-8370.

(*original signed by*:)
Sheila M. Cullen
Attachments

Facility Director Comments

Department of Veterans Affairs **Memorandum**

Date: March 3, 2013

From: Director, VA Palo Alto Health Care System (640/00)

Subject: **CAP Review of the VA Palo Alto Health Care System, Palo Alto, CA**

To: Director, Sierra Pacific Network (10N21)

1. Thank you for the opportunity to review the OIG CAP report of the VA Palo Alto Health Care System.

2. Please find attached our response to each recommendation provided in the report.

3. If you have any questions regarding the response to the recommendations in the report, feel free to call me at (650) 858-3939.

(*original signed by*:)
Elizabeth Joyce Freeman
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 actions from peer reviews are clearly defined and consistently tracked to completion at the service level.

Concur

Target date for completion: 2/14/13 (Completed)

Facility response: The Peer Review Committee assignment of action items has been altered to reflect direct assignment to the responsible supervisor. Assignment memoranda will be provided to the responsible supervisor as notification of the recommended action and will require confirmation of completion of the recommended action. The actions will be monitored in the PRC tracking log and reported in the monthly minutes.

Recommendation 2. We recommended that processes be strengthened to ensure that FPPEs for newly hired licensed independent practitioners are consistently completed.

Concur

Target date for completion: 5/31/13

Facility response: Clinical Administrative Officers (AO) and Chiefs have been reeducated on appropriate Initial Performance Evaluation (IPE) extension and conversion to Ongoing Professional Practice Evaluation (OPPE) processes for newly hired licensed independent practitioners. A list of delinquent physicians has been generated and clinical services will either extend the IPE for those physicians who need additional proctoring, or convert to OPPE, as appropriate. Updates will be reported at the Clinical AO meetings each month, beginning in March.

Recommendation 3. We recommended that processes be strengthened to ensure that the results of proficiency testing and the results of peer reviews when transfusions did not meet criteria are reported to the Transfusion Review Committee.

Concur

Target date for completion: 2/11/13 (Completed)

Facility response: The Transfusion Committee agenda now includes a standing item "Performance Improvement", which addresses proficiency testing and transfusion

monitoring when criteria is not met. The first agenda incorporating the change was February 11, 2013. Utilization data also includes a line item to track the number of notification letters sent when transfusions do not meet criteria.

Recommendation 4. We recommended that processes be strengthened to ensure that EOC Committee minutes reflect that actions taken in response to identified deficiencies are tracked to closure.

Concur

Target date for completion: 2/1/13 (Completed)

Facility response: The action items tracking log on EOC Committee minutes now reflect the action taken to correct deficiencies with dates of completion.

Recommendation 5. We recommended that processes be strengthened to ensure that sharps containers in the Menlo Park CLC are readily accessible to all staff.

Concur

Target date for completion: 2/25/13 (Completed)

Facility response: The sharps containers have been secured to the walls at the appropriate height.

Recommendation 6. We recommended that processes be strengthened to ensure that medication carts are secured at all times and that compliance be monitored.

Concur

Target date for completion: 6/30/13

Facility response: Nurse Managers are referred to the Nursing Policy 118-12-153, Safe Storage of Medications, at unit staff meetings as a continuous education tool to ensure the safety and security of medication carts. In addition, the Medication Management Committee distributed a flyer titled “Medication Safety Tips” to all inpatient units. This flyer includes information regarding the locking of the medication cart while the cart is unattended. Every Inpatient unit will conduct a monthly audit for 3 months on all shifts or continue to audit until 100% compliance is reached. The audit will include every medication room, medication cart, and Bar Code Medication Administration (BCMA) cart drawer to ensure they are locked and that locks are functional. Audit results will be monitored by Nursing Service. This audit will be reported to the Nursing Service Leadership Council through the Unit Based Councils, beginning April 2013.

Recommendation 7. We recommended that processes be strengthened to ensure that expired multi-dose vials are removed from medication carts in the CLC.

Concur

Target date for completion: 6/30/13

Facility response: All CLC units will assign night shift staff to check medication carts and unit medication refrigerators daily using an audit form for expired medications. Staff will check expiration dates on all multi-dose medication prior to administration. Local units have already set up a weekly audit process. Every CLC unit will conduct weekly audits for 3 months or continue to audit until 100% compliance is reached. This audit will be reported to the Nursing Service Leadership Council through the Unit Based Councils, beginning in April 2013.

Recommendation 8. We recommended that the facility fully implement the nurse staffing methodology.

Concur

Target date for completion: Full implementation and completion by 9/30/13

Facility response: The methodology implementation is currently 50% complete. The Nursing Staffing software package has been purchased. A designated team of Train-the Trainers has been established to enter data into the package and begin the initial training of nurse managers and staff. Initial Hours-Per-Patient-Day (HPPD) have been established for all inpatient units through their established Unit Based Councils.. Full implementation of Nursing Staffing Package will be accomplished by June 30, 2013. A Computer Assistant position has been established to continue the training of staff. With an expected on duty date of 6/30/13. Establishment of the Resource Management Council with oversight of the Nursing Staffing Methodology and leadership provided by the Associate Chief Nurse for Informatics will be put into place by 9/30/13. The oversight will include the forwarding of HPPD recommendations to the Associate Director for Patient Care Service/Nursing Services for approval as well a various reports relating to staffing effectiveness.

Recommendation 9. We recommended that managers initiate protected peer review for the one identified patient and complete any recommended review actions.

Concur

Target date for completion: 2/22/13 (Completed)

Facility response: Peer Review has been 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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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.
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