Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 13-00374-174

Combined Assessment Program Review of the Manchester VA Medical Center Manchester, New Hampshire

April 12, 2013

Washington, DC 20420

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

Glossary

CAP	Combined Assessment Program
CLC	community living center
CPRS	Computerized Patient Record System
CS	controlled substances
EHR	electronic health record
EOC	environment of care
facility	Manchester VA Medical Center
FPPE	Focused Professional Practice Evaluation
FY	fiscal year
HPC	hospice and palliative care
HRCP	Home Respiratory Care Program
IC	infection control
NA	not applicable
NC	noncompliant
OIG	Office of Inspector General
PCCT	Palliative Care Consult Team
PRC	Peer Review Committee
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 February 4, 2013.

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

- Environment of Care
- Nurse Staffing
- Preventable Pulmonary Embolism

The facility's reported accomplishments were the reduction in the facility's solid and regulated waste volumes, recognition of the community living center's culture transformation as a best practice, and implementation of new system redesign strategies to support the facility's process improvement activities.

Recommendations: We made recommendations in the following five activities:

Quality Management: Ensure actions from peer reviews are consistently completed and reported to the Peer Review Committee. Consistently complete Focused Professional Practice Evaluations for newly hired licensed independent practitioners, and report results to the Professional Standards Board. Ensure that the Code Committee reviews each code episode. Analyze electronic health record quality reviews.

Medication Management – Controlled Substances Inspections: Initiate actions to address the one identified physical security deficiency, and ensure all deficiencies identified during annual physical security surveys are corrected. Consistently reconcile 1 day's dispensing from the pharmacy to each automated unit, and monitor compliance.

Coordination of Care – Hospice and Palliative Care: Dedicate a psychologist and an administrative support person to the Palliative Care Consult Team. Require that all non-hospice and palliative care staff receive end-of-life training. Attach hospice and palliative care consult responses to the consult request in the Computerized Patient Record System.

Long-Term Home Oxygen Therapy: Ensure the Chief of Staff reviews Home Respiratory Care Program activities at least quarterly.

Construction Safety: Ensure that construction safety and infection surveillance activities related to construction projects are initiated at the same time as the projects and documented in the minutes of each committee.

Comments

The Veterans Integrated Service Network Director and Acting Facility Director agreed with the Combined Assessment Program review findings and recommendations and provided acceptable improvement plans. (See Appendixes C and D, pages 19–24, for the full text of the Directors' comments.) We will follow up on the planned actions until they are completed.

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

Objectives and Scope

Objectives

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

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

Scope

We reviewed selected clinical and administrative activities to evaluate compliance with requirements related to patient care quality and the EOC. In performing the review, we inspected selected areas, interviewed managers and employees, and reviewed clinical and administrative records. The review covered the following eight activities:

- QM
- EOC
- Medication Management – CS Inspections
- Coordination of Care – HPC
- Long-Term Home Oxygen Therapy
- Nurse Staffing
- Preventable Pulmonary Embolism
- Construction Safety

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

The review covered facility operations for FY 2011, FY 2012, and FY 2013 through February 7, 2013, and was done in accordance with OIG standard operating procedures for CAP reviews. We also asked the facility to provide the current status on the recommendations we made in our previous CAP report (*Combined Assessment Program Review of the Manchester VA Medical Center, Manchester, New Hampshire,* Report No. 10-00469-122, April 6, 2010). We made repeat recommendations in QM.

During this review, we presented crime awareness briefings for 215 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 197 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

Waste and Recycling Successes

Substantial improvements made in inventory management, staff training, and recycling by integrating the Green Environmental Management System program facility wide have reduced the facility's solid and regulated medical waste volumes. Between FY 2006 and FY 2012, solid waste decreased 28 percent from 239.1 tons to 171.97 tons, regulated medical waste decreased 19 percent from 23,240 pounds to 18,935 pounds, and the recycling rate increased from 11 percent to 49 percent.

Although the facility experienced an increase in the number of employees, in patient care square footage space for the medical and surgical outpatient clinic addition, and in outpatient visits, the reduction in solid waste has been maintained over time.

CLC Culture Transformation

The facility's CLC culture transformation was recognized by VISN 1 as a best practice. In 2005, a Culture Change Committee was formed to create a culture that provides resident centered care and an environment that is as home like as possible. Progress is measured by using the Artifacts of Culture Change Tool, which allows progression to be benchmarked against internal performance and the performance of other VA CLCs. The facility's score has consistently been the highest in VISN 1 and exceeded the national average for FY 2012 and the 1st quarter of FY 2013. The Culture Change Committee maintains an updated action plan to identify and implement projects so that progress is ongoing.

Accomplishments include the implementation of "I" format care plans, which are care plans written in the first person and in the voice of the resident and a computer lab with 24-hour internet access and adaptations to accommodate individualized resident needs. Unique relationships with Veteran Service Organizations and community partners enable the facility to obtain funding and volunteer support for special programs and the purchase of equipment.

System Redesign Strategies

In FY 2012, managers implemented new system redesign strategies to aid the facility's process improvement activities. One strategy is using Huddle Boards[a] to support staff in making "everyday improvements"[b] in their work areas, such as ensuring that extension tubing for the wall mounted oxygen outlet in a radiology exam room will reach every corner of the exam room in an emergency.

A second strategy is using engaged work teams that meet regularly to review performance data and work collectively on care improvement projects. Leadership recognized 50 work teams for meeting projects' required outcome criteria. One project focused on improving access to the amputee clinic and reducing the wait time for follow-up appointments for patients who were issued prostheses.

A third strategy is the use of charter teams. The teams focus on projects to improve care or to reach strategic facility objectives. Several charter teams are focusing on items identified in the All Employee Survey, such as work life balance.

Improvement projects are shared throughout the facility during monthly senior management rounds to the different services, during weekly improvement showcases for supervisors and managers, and by posting projects to the facility's homepage for all staff to review. All of the improvement efforts focus on creating a patient centered culture.

[a] A Huddle Board is a tri-fold poster that has six sections with specific work steps to assist staff in making improvements in their work areas.
[b] An "everyday improvement" is a small improvement idea that front line staff identify and work on to improve the care, services, or experience of the patient and the staff's day to day work.

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.	
NA	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 PRC.	Six months of PRC meeting minutes reviewed: • Of the six actions expected to be completed, five were not reported to the PRC. This was a repeat finding from the previous CAP review.
X	FPPEs for newly hired licensed independent practitioners complied with selected requirements.	Fourteen profiles reviewed: • Of the 14 FPPEs initiated, 2 were not completed. • Of the 12 FPPEs completed, results of 5 were not reported to the Professional Standards Board. These were repeat findings from the previous CAP review.
	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.	
NA	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.	

NC	Areas Reviewed (continued)	Findings
X	The cardiopulmonary resuscitation review policy and processes complied with requirements for reviews of episodes of care where resuscitation was attempted.	Six months of Code 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: • EHR quality reviews were not analyzed.
	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 actions from peer reviews are consistently completed and reported to the PRC.

2. We recommended that processes be strengthened to ensure that FPPEs for newly hired licensed independent practitioners are consistently completed and that results are consistently reported to the Professional Standards Board.

3. We recommended that processes be strengthened to ensure that the Code Committee reviews each code episode.

4. We recommended that processes be strengthened to ensure that EHR quality reviews are analyzed.

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 CLC and palliative care units and the urgent care, primary care, women's health, physical therapy, and occupational therapy clinics. Additionally, we reviewed relevant documents and 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 8 CS areas, the pharmacy, and the emergency drug cache. The table below shows the areas reviewed for this topic. The areas marked as NC needed improvement. Items that did not apply to this facility are marked "NA."

NC	Areas Reviewed	Findings
	Facility policy was consistent with VHA requirements.	
X	VA police conducted annual physical security surveys of the pharmacy/pharmacies, and any identified deficiencies were corrected.	Annual physical security surveys for past 2 years reviewed: • One identified deficiency had not been corrected, and a work order had not been submitted to correct the deficiency.
X	Instructions for inspecting automated dispensing machines were documented, included all required elements, and were followed.	Automated dispensing machine inspection instructions reviewed: • Although instructions required reconciliation of 1 day's dispensing from the pharmacy to each automated unit, this was not consistently done for three CS areas.
	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.	

Recommendations

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

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

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, 19 EHRs of patients who had PCCT consults (including 10 HPC inpatients), and 20 employee training records (5 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: • A psychologist and 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 15 non-HPC staff, there was no evidence that 3 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 CPRS.	
	The PCCT responded to consults within the required timeframe and tracked consults that had not been acted upon.	
X	Consult responses were attached to HPC consult requests.	• Four consult responses were not attached to the consult request in the CPRS.
	The facility submitted the required electronic data for HPC through the VHA Support Service Center.	
	An interdisciplinary team care plan was completed for HPC inpatients within the facility's specified timeframe.	
	HPC inpatients were assessed for pain with the frequency required by local policy.	
	HPC inpatients' pain was managed according to the interventions included in the care plan.	
	HPC inpatients were screened for an advanced directive upon admission and according to local policy.	

NC	Areas Reviewed (continued)	Findings
	The facility complied with any additional elements required by VHA or local policy.	

Recommendations

7. We recommended that the PCCT includes a dedicated psychologist and administrative support person.

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

9. We recommended that processes be strengthened to ensure that HPC consult responses are attached to the consult request in the CPRS.

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 33 EHRs of patients enrolled in the home oxygen program (including 5 patients deemed to be high risk), and we interviewed key employees. The table below shows the areas reviewed for this topic. The area marked as NC needed improvement. Items that did not apply to this facility are marked "NA."

NC	Areas Reviewed	Findings
	There was a local policy to reduce the fire hazards of smoking associated with oxygen treatment.	
X	The Chief of Staff reviewed HRCP activities at least quarterly.	HRCP meeting minutes between July 1, 2011, and June 30, 2012, reviewed: • 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.	
	Home oxygen program patients had active orders/prescriptions for home oxygen and were re-evaluated for home oxygen therapy annually after the first year.	
	Patients identified as high risk received hazards education at least every 6 months after initial delivery.	
	NC high-risk patients were identified and referred to a multidisciplinary clinical committee for review.	
	The facility complied with any additional elements required by VHA or local policy.	

Recommendation

10. We recommended that processes be strengthened to ensure that the Chief of Staff reviews HRCP activities at least quarterly.

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 one selected unit (long-term care).[6]

We reviewed relevant documents and 11 training files, and we interviewed key employees. Additionally, we reviewed the actual nursing hours per patient day for CLC unit 2 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 11 EHRs of patients with confirmed diagnoses of pulmonary embolism[c] January 1–June 30, 2012. We also interviewed key employees. The table below shows the areas reviewed for this topic. Items that did not apply to this facility are marked "NA." The facility generally met requirements. We made no recommendations.

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

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

Construction Safety

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

We inspected the heating, ventilation, and air conditioning renovation project in the same day surgery suite. Additionally, we reviewed relevant documents and 20 training records (10 contractor records and 10 employee records), and we interviewed key employees and managers. The table below shows the areas reviewed for this topic. The areas marked as NC needed improvement. Items that did not apply to this facility are marked "NA."

NC	Areas Reviewed	Findings
	There was a multidisciplinary committee to oversee IC and safety precautions during construction and renovation activities and a policy outlining the responsibilities of the committee, and the committee included all required members.	
	IC, preconstruction, interim life safety, and contractor tuberculosis risk assessments were conducted prior to project initiation.	
NA	There was documentation of results of contractor tuberculosis skin testing and of follow-up on any positive results.	
	There was a policy addressing Interim Life Safety Measures, and required Interim Life Safety Measures were documented.	
	Site inspections were conducted by the required multidisciplinary team members at the specified frequency and included all required elements.	
X	IC Committee minutes documented infection surveillance activities associated with the project(s) and any interventions.	IC Committee minutes for past 2 quarters reviewed: • Although all applicable standards were being met at the time of the site visit, 2 quarters of documentation were not available for review because many procedures were only recently instituted.
X	Construction Safety Committee minutes documented any unsafe conditions found during inspections and any follow-up actions and tracked actions to completion.	Construction Safety Committee minutes for past 2 quarters reviewed: • Although all applicable standards were being met at the time of the site visit, 2 quarters of documentation were not available for review because many procedures were only recently instituted.
	Contractors and designated employees received required training.	

NC	Areas Reviewed (continued)	Findings
	Dust control requirements were met.	
	Fire and life safety requirements were met.	
	Hazardous chemicals requirements were met.	
	Storage and security requirements were met.	
	The facility complied with any additional elements required by VHA or local policy or other regulatory standards.	

Recommendation

11. We recommended that processes be strengthened to ensure that construction safety and infection surveillance activities related to construction projects are initiated at the same time as the projects and documented in the minutes of each committee.

Facility Profile (Manchester/608) FY 2012[d]	
Type of Organization	Secondary
Complexity Level	3-Low complexity
Affiliated/Non-Affiliated	Non-affiliated
Total Medical Care Budget in Millions	$136.2
Number of:	
• **Unique Patients**	24,274
• **Outpatient Visits**	247,551
• **Unique Employees[e] (as of last pay period in FY 2012)**	543
Type and Number of Operating Beds:	
• **Hospital**	0
• **CLC**	112
• **Mental Health**	0
Average Daily Census: (through August 2012)	
• **Hospital**	NA
• **CLC**	33.3
• **Mental Health**	NA
Number of Community Based Outpatient Clinics	4
Location(s)/Station Number(s)	Portsmouth/608GA Somersworth/608GC Conway/608GD Tilton/608HA
VISN Number	1

[d] All data is for FY 2012 except where noted.
[e] 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 and outpatient satisfaction scores for FY 2012.

Table 1

	Inpatient Scores		Outpatient Scores			
	FY 2012		FY 2012			
	Inpatient Score Quarters 1–2	Inpatient Score Quarters 3–4	Outpatient Score Quarter 1	Outpatient Score Quarter 2	Outpatient Score Quarter 3	Outpatient Score Quarter 4
Facility	NA	NA	58.1	54.8	70.6	66.3
VISN	65.7	67.6	60.8	59.9	65.3	61.7
VHA	63.9	65.0	55.0	54.7	54.3	55.0

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: March 26, 2013

From: Director, VA New England Healthcare System (10N1)

Subject: **CAP Review of the Manchester VA Medical Center, Manchester, NH**

To: Director, Bedford Office of Healthcare Inspections (54BN)

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

I have reviewed and concur with the action plans included in the attached memorandum regarding the Combined Assessment Program Review, Manchester VAMC, Manchester, NH.

Sincerely,

(*original signed by*:)
Michael Mayo-Smith, MD, MPH
Network Director

Acting Facility Director Comments

Department of Veterans Affairs **Memorandum**

Date: March 22, 2013

From: Acting Director, Manchester VA Medical Center (608/00)

Subject: **CAP Review of the Manchester VA Medical Center, Manchester, NH**

To: Director, VA New England Healthcare System (10N1)

I have reviewed and concur with the action plans included in the attached memorandum regarding the Combined Assessment Program Review, Manchester VAMC, Manchester, NH.

Sincerely,

(*original signed by Tammy A. Krueger for*:)
Susan A. MacKenzie
Acting Medical Center Director

Comments to OIG's Report

The following Acting 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 consistently completed and reported to the PRC.

Concur

Target date for completion: April 5, 2013

Facility response: The Peer Review tracking spreadsheet has been revised to include a column which identifies the completion date of action items related to Peer Reviews. Action item status is now a specific agenda item and will be reviewed at each meeting.

Recommendation 2. We recommended that processes be strengthened to ensure that FPPEs for newly hired licensed independent practitioners are consistently completed and that results are consistently reported to the Professional Standards Board.

Concur

Target date for completion: March 22, 2013

Facility response: A tracking spreadsheet was developed which is reviewed at each Professional Standards Board meeting and is maintained by the Credentialing and Privileging Coordinator. The spreadsheet includes the name, date of employment, due date and responsible party for the FPPE of the newly hired licensed independent practitioner. The spreadsheet includes a column which reflects the date the FPPE was reviewed by the Professional Standards Board and will close the review.

Recommendation 3. We recommended that processes be strengthened to ensure that the Code Committee reviews each code episode.

Concur

Target date for completion: April 4, 2013

Facility response: There is now a standing agenda item entitled "cardiopulmonary resuscitation review." The Chairperson of the Code Committee will review each resuscitation event using the "Code Review" form with the committee members.

Recommendation 4. We recommended that processes be strengthened to ensure that EHR quality reviews are analyzed.

Concur

Target date for completion: April 11, 2013

Facility response: A Standard Operating Procedure was developed which delineates the responsibilities of the Medical Records committee and their roles regarding record review, analysis and action plans for improvement. Data and analysis is being reported and discussed at the monthly meeting.

Recommendation 5. We recommended that managers initiate actions to address the one identified physical security deficiency and that processes be strengthened to ensure that all deficiencies identified during annual physical security surveys are corrected.

Concur

Target date for completion: April 30, 2013

Facility response: Outside contractor was assigned to complete work on upgrading intrusion detection system in pharmacy. Work to begin on April 12, 2013 to bring this physical security deficiency into compliance with the national standard. The annual physical security surveys will now be tracked to completion by the Environment of Care committee.

Recommendation 6. We recommended that processes be strengthened to ensure that 1 day's dispensing from the pharmacy to each automated unit is consistently reconciled and that compliance be monitored.

Concur

Target date for completion: March 14, 2013

Facility response: The Standard Operating Procedure has been revised to ensure that inspectors will review a full month of data in the event there was no dispensing activity on the 1 day selected for the inspection. The process change has been communicated to all inspectors and incorporated into inspection report forms and other documentation that is provided to the Controlled Substance Coordinator for ongoing monitoring of the inspection process.

Recommendation 7. We recommended that the PCCT includes a dedicated psychologist and administrative support person.

Concur

Target date for completion: May 1, 2013

Facility response: The current Palliative Care Unit administrative assistant is labor mapped .25 to the PCCT team. The functional statement has been revised to include duties for the PCCT and the incumbent will be oriented to the role.

A resource request for an additional 0.6 psychologist has been submitted to the local Resource Board by the Mental Health Service Line Manager. The plan would be to labor map .25 to the PCCT. The interim plan is to cover the hours with current psychologist staff and provide orientation to the role.

Recommendation 8. We recommended that processes be strengthened to ensure that all non-HPC staff receive end-of-life training.

Concur

Target date for completion: June 1, 2013

Facility response: A Talent Management System educational program on palliative/end of life care will be assigned to all Manchester VA staff, who have not previously completed a training program. Compliance reports will be completed by the education department and monitored through the Quality Executive Board for compliance.

Recommendation 9. We recommended that processes be strengthened to ensure that HPC consult responses are attached to the consult request in the CPRS.

Concur

Target date for completion: May 1, 2013

Facility response: The PCCT administrative assistant will track all HPC consults to ensure responses are linked appropriately to the consult. The PCCT will be educated regarding the new process in April, 2013.

Recommendation 10. We recommended that processes be strengthened to ensure that the Chief of Staff reviews HRCP activities at least quarterly.

Concur

Target date for completion: March 1, 2013

Facility response: The Chief of Staff is reviewing and signing the minutes for the Home Respiratory Care committee to ensure that he is aware of the committee activities.

Recommendation 11. We recommended that processes be strengthened to ensure that construction safety and infection surveillance activities related to construction projects are initiated at the same time as the projects and documented in the minutes of each committee.

Concur

Target date for completion: April 15, 2013

Facility response: The Infection Control Committee minutes have been revised to include a standing agenda item for construction projects. These will be reviewed at each committee meeting. The Construction Project Safety committee will continue to utilize a spreadsheet which includes infection surveillance activities for each construction project and is regularly discussed at the Construction Subcommittee meetings held weekly. The Infection Preventionist will now be required to bring new construction infection surveillance issues to the Construction Safety committee on a monthly basis for review.

OIG Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the OIG at (202) 461-4720.
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Senate Committee on Homeland Security and Governmental Affairs
National Veterans Service Organizations
Government Accountability Office
Office of Management and Budget
U.S. Senate: Kelly Ayotte, Jeanne Shaheen
U.S. House of Representatives: Carol Shea-Porter

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

Endnotes

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