Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 12-03746-161

Combined Assessment Program Review of the VA Pittsburgh Healthcare System Pittsburgh, Pennsylvania

May 2, 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: http://www.va.gov/oig/hotline/default.asp)

Glossary

CAP	Combined Assessment Program
CLC	community living center
CS	controlled substances
EHR	electronic health record
EOC	environment of care
facility	VA Pittsburgh Healthcare System
FPPE	Focused Professional Practice Evaluations
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 October 29, 2012.

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

- Medication Management – Controlled Substances Inspections
- Nurse Staffing
- Preventable Pulmonary Embolism

The facility's reported accomplishments were an Interdisciplinary Medical Perioperative Assessment Consultation and Treatment Service and a full-home simulation training program in the community living center.

Recommendations: We made recommendations in the following five activities:

Quality Management: Consistently initiate Focused Professional Practice Evaluations for newly hired licensed independent practitioners, and gather data about observation bed use. Review the quality of entries in the electronic health record.

Environment of Care: Ensure the Consolidation Building has fire extinguisher signage in place in accordance with National Fire Protection Association standards. Transport post-operative patients in clean elevators.

Coordination of Care – Hospice and Palliative Care: Ensure non-hospice and palliative care staff receive end-of-life training.

Long-Term Home Oxygen Therapy: Ensure that the Chief of Staff reviews Home Respiratory Care Program activities at least quarterly and that all Home Oxygen Plan of Care notes have a physician co-signature.

Construction Safety: Ensure the construction and renovation activities multidisciplinary committee continues to meet. Conduct contractor tuberculosis risk assessments prior to construction project initiation, and document contractor tuberculosis skin test results. Include all required elements in construction site inspection documentation. Require that Infection Control Committee minutes contain documentation of infection surveillance activities related to construction projects. Ensure designated employees receive initial and ongoing construction safety training, and monitor compliance.

Comments

The Veterans Integrated Service Network and Facility Directors agreed with the Combined Assessment Program review findings and recommendations and provided acceptable improvement plans. (See Appendixes C and D, pages 17–22, for the full text of the Directors' comments.) We consider recommendations 4 and 5 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 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 2012 and FY 2013 through October 26, 2012, 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 Pittsburgh Healthcare System, Pittsburgh, Pennsylvania,* Report No. 11-01107-243, August 2, 2011).

During this review, we presented crime awareness briefings for 160 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 211 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

Interdisciplinary Medical Perioperative Assessment Consultation and Treatment Service Clinic

The facility developed an Interdisciplinary Medical Perioperative Assessment Consultation and Treatment Service clinic that provides a centralized, multidisciplinary approach to risk stratification and medical optimization in the perioperative period. The goal of this clinic is to improve surgical outcomes through perioperative optimization of co-morbid conditions and post-operative planning for care management. After opening the clinic, the facility documented decreases in morbidity and mortality rates in neurosurgery and orthopedics as compared to FY 2010.

MyHome

The facility's *MyHome* is a full-home simulation training program in the CLC. *MyHome* features a functional kitchen, bathroom, living room, bedroom, hallway, dining room, staircase with banister, and garage with a car. This space allows rehabilitation therapists to observe and train patients as they face real home challenges, including rising from a bed or sofa, putting away groceries, getting in and out of a bathtub, doing laundry, and navigating home safety issues like walking across varied floor surfaces.

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	FPPE for newly hired licensed independent practitioners complied with selected requirements.	Twelve profiles reviewed: • Six FPPE were not initiated.
	Local policy for the use of observation beds complied with selected requirements.	
X	Data regarding appropriateness of observation bed use was gathered, and conversions to acute admissions were less than 30 percent.	• The facility did not gather observation bed use data.
	Staff performed continuing stay reviews of 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.	
X	There was an EHR quality review committee, and the review process complied with selected requirements.	Twelve months of Clinical Informatics Team meeting minutes reviewed: • There was no evidence that the quality of entries in the EHR was reviewed.
	The EHR copy and paste function was monitored.	

NC	Areas Reviewed (continued)	Findings
	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 FPPE for newly hired licensed independent practitioners are consistently initiated.

2. We recommended that processes be strengthened to ensure that data about observation bed use is gathered.

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

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 H.J. Heinz campus, we inspected the dementia specialty unit, long-term care unit, transitional care unit, hospice unit, primary care clinic, and dental clinic. At the University Drive campus, we inspected the observation unit, 6W medical and liver transplant unit, 4W surgical, step down unit telemetry, cardiac care unit, dialysis unit, chemotherapy clinic, electrophysiology/cardiac catheterization unit, emergency department, healthy women's veterans clinic, and physical medicine and rehabilitation clinic. In the Consolidation Building, we inspected the 3CB extended care unit, 4CB and 5CB acute psychiatric admission units, and behavioral health outpatient clinic. 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.	
	Patient care areas were clean.	
X	Fire safety requirements were met.	• None of the fire extinguishers in the Mental Health Service's Consolidation Building had signage that identified the location of the extinguishers.
	Environmental safety requirements were met.	
X	Infection prevention requirements were met.	• Post-operative patients were transported from the operating room to the floors using a dirty freight elevator.
	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.	

NC	Areas Reviewed for the Women's Health Clinic	Findings
	The Women Veterans Program Manager completed required annual EOC evaluations and tracked identified 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.	
	Patient privacy requirements were met.	
	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.	
	Areas Reviewed for Physical Medicine and Rehabilitation Therapy Clinics	
	Fire safety requirements were met.	
	Environmental safety requirements were met.	
	Infection prevention requirements were met.	
	Medication safety and security requirements were met.	
	Patient privacy requirements were met.	
	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.	

Recommendations

4. We recommended that the Consolidation Building have fire extinguisher signage in place in accordance with National Fire Protection Association standards.

5. We recommended that processes be strengthened to ensure that post-operative patients are transported using clean elevators.

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 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. The area marked as NC needed improvement. Items that did not apply to this facility are marked "NA."

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.	
X	HPC staff and selected non-HPC staff had end-of-life training.	• Of the 15 non-HPC staff, there was no evidence that 13 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.	

Recommendation

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

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 7 patients deemed to be high risk), and we interviewed key employees. The table below shows the areas reviewed for this topic. The areas marked as NC needed improvement. Items that did not apply to this facility are marked "NA."

NC	Areas Reviewed	Findings
	There was a local policy to reduce the fire hazards of smoking associated with oxygen treatment.	
X	The Chief of Staff reviewed Home Respiratory Care Program activities at least quarterly.	• We found no evidence that program activities were reviewed quarterly.
	The facility had established a home respiratory care team.	
	Contracts for oxygen delivery contained all required elements and were monitored quarterly.	
	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.	
X	The facility complied with any additional elements required by VHA or local policy.	• Sixteen (46 percent) Home Oxygen Plan of Care notes did not have a physician co-signature in accordance with local policy.

Recommendations

7. We recommended that processes be strengthened to ensure that the Chief of Staff reviews Home Respiratory Care Program activities at least quarterly.

8. We recommended that processes be strengthened to ensure that all Home Oxygen Plan of Care notes have a physician co-signature.

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 26 training files, and we interviewed key employees. Additionally, we reviewed the actual nursing hours per patient day for acute care unit 4W and CLC unit 1 South 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 17 EHRs of patients with confirmed diagnoses of pulmonary embolism[a] January 1–June 30, 2012. We also interviewed key employees. The table below shows the areas reviewed for this topic. The areas marked as NC needed improvement. Items that did not apply to this facility are marked "NA." The facility generally met requirements. We made no recommendations.

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

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

Construction Safety

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

We inspected the primary care and 3W same day surgery construction projects at the University Drive campus. 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
X	There was a multidisciplinary committee to oversee infection control and safety precautions during construction and renovation activities and a policy outlining the responsibilities of the committee, and the committee included all required members.	• The facility did not have a multidisciplinary committee to oversee construction and renovation activities prior to June 2012.
X	Infection control, preconstruction, interim life safety, and contractor tuberculosis risk assessments were conducted prior to project initiation.	Risk assessments reviewed: • Contractor tuberculosis risk assessments were not conducted prior to either project's initiation.
X	There was documentation of results of contractor tuberculosis skin testing and of follow-up on any positive results.	• Contractor tuberculosis skin test results were not documented.
	There was a policy addressing Interim Life Safety Measures, and required Interim Life Safety Measures were documented.	
X	Site inspections were conducted by the multidisciplinary team members at the specified frequency and included all required elements.	Site inspection documentation for 2 quarters reviewed: • Site inspections did not include all required elements.
X	Infection Control Committee minutes documented infection surveillance activities associated with the project(s) and any interventions.	Infection Control Committee minutes for past 2 quarters reviewed: • There was no documentation of infection surveillance activities related to either project.
	Construction Safety Committee minutes documented any unsafe conditions found during inspections and any follow-up actions and tracked actions to completion.	

NC	Areas Reviewed (continued)	Findings
X	Contractors and designated employees received required training.	Employee and contractor training records reviewed: • Three employee records did not contain evidence of initial VHA or Occupational Safety and Health Administration Construction Safety training. • Eight employee records did not contain evidence of at least 10 hours of construction safety-related training in the past 2 years.
	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.	

Recommendations

9. We recommended that the construction and renovation activities multidisciplinary committee continues to meet.

10. We recommended that processes be strengthened to ensure that contractor tuberculosis risk assessments are conducted prior to construction project initiation.

11. We recommended that processes be strengthened to ensure that contractor tuberculosis skin test results are documented.

12. We recommended that processes be strengthened to ensure that construction site inspection documentation includes all the required elements.

13. We recommended that processes be strengthened to ensure that infection surveillance activities related to construction projects are documented in Infection Control Committee minutes.

14. We recommended that processes be strengthened to ensure that designated employees receive initial and ongoing construction safety training and that compliance be monitored.

Facility Profile (Pittsburgh/646) FY 2012[b]	
Type of Organization	Tertiary
Complexity Level	1a-High complexity
Affiliated/Non-Affiliated	Affiliated
Total Medical Care Budget in Millions (through August 2012)	$542.8
Number of:	
• **Unique Patients**	65,665
• **Outpatient Visits**	636,766
• **Unique Employees**[c]	2,321
Type and Number of Operating Beds: (through August 2012)	
• **Hospital**	225
• **CLC**	262
• **Mental Health**	84
Average Daily Census: (through August 2012)	
• **Hospital**	174
• **CLC**	200
• **Mental Health**	72
Number of Community Based Outpatient Clinics	5
Location(s)/Station Number(s)	Beaver County/646GC Fayette County/646GE Belmont County/646GA Washington County/646GD Westmoreland County/646GB
VISN Number	4

[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 and outpatient satisfaction scores for quarters 3–4 of FY 2011 and quarters 1–2 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 3	Outpatient Score Quarter 4	Outpatient Score Quarter 1	Outpatient Score Quarter 2
Facility	67.7	68.7	58.9	64.2	60.9	62.1
VISN	67.4	66.9	61.1	61.6	59.5	60.5
VHA	64.1	63.9	54.2	54.5	55.0	54.7

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	13.7	11.5	13.0	18.1	26.0	19.7
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: March 19, 2013

From: Director, VA Healthcare – VISN 4 (10N4)

Subject: **CAP Review of the VA Pittsburgh Healthcare System, Pittsburgh, PA**

To: Director, Washington, DC, Office of Healthcare Inspections (54DC)

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

I have reviewed the draft report of the VA Pittsburgh Healthcare System. I concur with the findings and the facilities response.

(original signed by:)
Michael E. Moreland, FACHE

Facility Director Comments

Department of Veterans Affairs **Memorandum**

Date: March 4, 2013

From: Director, VA Pittsburgh Healthcare System (646/00)

Subject: **CAP Review of the VA Pittsburgh Healthcare System, Pittsburgh, PA**

To: Director, VA Healthcare – VISN 4 (10N4)

1. The findings from the VA Pittsburgh Healthcare System Combined Assessment Program (CAP) review by the Office of the Inspector General (OIG) conducted October 29, through November 2, 2012 have been reviewed.

2. Attached are the facility responses addressing each recommendation, including actions that are in progress and those that have already been completed.

(original signed by:)
Terry Gerigk Wolf, FACHE
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 FPPE for newly hired licensed independent practitioners are consistently initiated.

Concur

Target date for completion: September 30, 2013

Facility response: The Program Support Assistant for the Chief of Staff sends an electronic FPPE template for the newly reporting licensed independent practitioner to the Service Line Vice President 90 days before the due date. Second and third reminders are sent at 30 and 7 days respectively before the due date. The same FPPE template is used for all licensed independent practitioners.

Recommendation 2. We recommended that processes be strengthened to ensure that data about observation bed use is gathered.

Concur

Target date for completion: September 30, 2013

Facility response: Data for the conversion of observation status to admission status has been added to the monthly UM data dashboard. This report is presented quarterly to the Executive Leadership Board. Conversion data was presented at the February 7, 2013 meeting.

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

Concur

Target date for completion: July 31, 2013

Facility response: A monitoring tool has been developed for each of the clinical service lines which list six elements to evaluate the quality of medical record entries. These are as follows: presence of documentation to identify patient's complaint/reason for admission, plan of care is documented in a timely manner for all parties to decipher, consistency of diagnosis(es) based on assessments and treatment provided, conclusions/recommendations accurately reflect plan of care, diagnostic and therapeutic tests are appropriate for symptoms, complaints or findings, and, authentication of documents are by credentialed, licensed providers authorized to

document in the electronic health record. Each service line has identified a reviewer who will complete 6 inpatient and 6 outpatient reviews each month. A summary report will be prepared by HIMS Program Leader and reviewed each quarter by the Clinical Informatics Committee beginning with third quarter FY13.

Recommendation 4. We recommended that the Consolidation Building have fire extinguisher signage in place in accordance with National Fire Protection Association standards.

Concur

Target date for completion: March 1, 2013

Facility response: Fire extinguisher signs have been installed above all extinguisher cabinets in all locations in the Consolidation Building except for the locked inpatient mental health units. Because those cabinets are locked, all staff assigned to those three units have been assigned a key along with training identifying the specific locations of all the extinguishers.

Recommendation 5. We recommended that processes be strengthened to ensure that post-operative patients are transported using clean elevators.

Concur

Target date for completion: March 1, 2013

Facility response: All post-operative patients are transported using the bed tower elevators. These elevators are only used for patient and/or staff transport.

Recommendation 6. We recommended that processes be strengthened to ensure that non-HPC staff receive end-of-life training.

Concur

Target date for completion: June 30, 2013

Facility response: End-of–life training has been added to the mandatory annual training modules for all nurses in the Critical Care Center and the Emergency Department. This training has been added to module two of four. Module two will be conducted in May and June, 2013.

Recommendation 7. We recommended that processes be strengthened to ensure that the Chief of Staff reviews Home Respiratory Care Program activities at least quarterly.

Concur

Target date for completion: June 30, 2013

Facility response: The last 12 months of minutes for the Home Respiratory Care Program were sent to the Chief of Staff for review and signature on February 1, 2013. Following this review, the minutes will be sent for concurrence and signature each quarter.

Recommendation 8. We recommended that processes be strengthened to ensure that all Home Oxygen Plan of Care notes have a physician co–signature.

Concur

Target date for completion: September 30, 2013

Facility response: The author of the plan of care note identifies the provider as a co-signer to the note in the electronic medical record. The provider then receives a View Alert which identifies a note to be signed.

Recommendation 9. We recommended that the construction and renovation activities multidisciplinary committee continues to meet.

Concur

Target date for completion: June 30, 2013

Facility response: The Construction Safety Committee has been meeting monthly since August, 2012. Meetings are regularly scheduled for the second Thursday of each month. Electronic calendar meeting requests are sent to each member monthly.

Recommendation 10. We recommended that processes be strengthened to ensure that contractor tuberculosis risk assessments are conducted prior to construction project initiation.

Concur

Target date for completion: June 30, 2013

Facility response: Tuberculosis screening has been added to MCM-EC 051 Construction and Safety during Construction. Infection Prevention staff have developed a Tuberculosis Risk Assessment which will be used for each new construction project. The completed assessment will be sent to the project COTR to be maintained with all paperwork related to the respective project.

Recommendation 11. We recommended that processes be strengthened to ensure that contractor tuberculosis skin test results are documented.

Concur

Target date for completion: June 30, 2013

Facility response: All new contracts for construction will include the requirement that all contracted employees working on site must have had the two step TST test within 90 days of the start of the project. Facilities Management Service will monitor the compliance for this contract requirement. Documentation of testing and training from the employees of the contractor and any subcontractors is to be submitted no later than 90 days prior to the start of the project. The project COTR is responsible for ensuring that the documentation has been received and for maintaining the project document file. The Project Manager has overall accountability for this procedure.

Recommendation 12. We recommended that processes be strengthened to ensure that construction site inspection documentation includes all the required elements.

Concur

Target date for completion: June 30, 2013

Facility response: A standardized safety inspection form was developed to insure that all elements of any construction site inspection are assessed and documented. Emphasis is placed on immediate resolution of any safety violation. Completed forms are maintained with all other individual project documents.

Recommendation 13. We recommended that processes be strengthened to ensure that infection surveillance activities related to construction projects are documented in Infection Control Committee minutes.

Concur

Target date for completion: July 31, 2013

Facility response: A representative from Facilities Management Service has been added to the Infection Control Committee membership. Construction has been added as a standing item for every agenda. Current projects are discussed. Deficiencies noted during rounds as well as immediate corrective actions taken to correct deficiencies are discussed and recorded in the minutes.

Recommendation 14. We recommended that processes be strengthened to ensure that designated employees receive initial and ongoing construction safety training and that compliance be monitored.

Concur

Target date for completion: June 30, 2013

Facility response: The Construction Safety Committee has been charged with tracking and the compliance with initial and ongoing construction safety training. All required training will be completed by March 31, 2013.

OIG Contact and Staff Acknowledgments

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Endnotes

[1] References used for this topic included:
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[7] The reference used for this topic was:
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