Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 13-00433-199

Combined Assessment Program Review of the Robley Rex VA Medical Center Louisville, Kentucky

May 20, 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	Robley Rex VA Medical Center
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
WVPM	Women Veteran Program Manager

Table of Contents

Executive Summary

Review Purpose: The purpose of the review was to evaluate selected health care facility operations, focusing on patient care quality and the environment of care, and to provide crime awareness briefings. We conducted the review the week of February 25, 2013.

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

- Medication Management – Controlled Substances Inspections
- Coordination of Care – Hospice and Palliative Care
- Nurse Staffing
- Preventable Pulmonary Embolism
- Construction Safety

The facility's reported accomplishments were the Operation Warfighter program, the Healthcare for Homeless Program, and art programs.

Recommendations: We made recommendations in the following three activities:

Quality Management: Ensure actions from peer reviews are completed and reported to the Peer Review Committee. Revise the local observation bed policy to include all required elements. Include all services in the review of electronic health record quality. Ensure the quality control process for scanning includes methods to ensure scanned documents are linked to the correct electronic health record.

Environment of Care: Require that Environment of Care Committee minutes reflect that actions taken in response to identified deficiencies are tracked to closure. Ensure the Women Veteran Program Manager completes the required annual environment of care evaluation. Track identified women's health-related environment of care deficiencies to closure. Ensure examination and treatment rooms designated for female patients have door locks. Complete an After Installation Checklist for the ceiling lift in the physical therapy clinic.

Long-Term Home Oxygen Therapy: Ensure the Chief of Staff reviews Home Respiratory Care Program activities at least quarterly. Re-evaluate home oxygen program patients in a timely manner.

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 15–19, 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 2012 and FY 2013 through February 25, 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 Robley Rex VA Medical Center, Louisville, Kentucky,* Report No. 10-00047-34, November 29, 2010).

During this review, we presented crime awareness briefings for 233 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 107 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

Operation Warfighter Program

The Operation Warfighter program provides education, training, and possible job placement for wounded warriors, including veterans who have traumatic brain injuries or post-traumatic stress disorder. The program, in collaboration with other military and civilian government agencies, helps veterans develop and better understand their abilities to function in society's current and future work environments. To date, 37 veterans have participated in the program collectively logging 10,565 working hours and resulting in a cost savings of $230,211.

Homeless Veterans Program

The facility's Healthcare for Homeless Veterans Program provided care for 56 homeless and/or at risk veterans during FY 2012. Through program efforts, there was a 24 percent decrease (314 to 204) in homeless veterans from 2011 to 2012. In addition, the program team participated in the national 100,000 Homes Campaign to identify the most vulnerable homeless veterans and target them for housing. Of the 22 eligible veterans identified in this project, 6 are now permanently housed, 6 used other transitional housing programs, 2 are incarcerated, 2 left the area, and 4 declined services. Program team members are searching for the remaining four veterans through street outreach.

Arts in Healing Program

In August 2011, the facility partnered with the Kentucky Center Arts in Healing program to provide art programs in a health care environment that are uplifting for patients and their families. Based on evidence-based research, the program includes design, visual, performing, and literary arts. As of February 2013, 213 hours of music, visual art, storytelling, and dance have been provided to veterans, families, and caregivers throughout the facility with great success.

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.	Six months of Peer Review Committee meeting minutes reviewed: • None of the 16 actions expected to be completed were reported to the Peer Review Committee.
	Focused Professional Practice Evaluations for newly hired licensed independent practitioners complied with selected requirements.	
X	Local policy for the use of observation beds complied with selected requirements.	The facility's policy did not include the following: • That each admission must have a limited severity of illness • That each admission must have a condition appropriate for observation • How the physician responsible for the patient's care is determined
	Data regarding appropriateness of observation bed use was gathered, and conversions to acute admissions were less than 30 percent, or the facility had reassessed observation criteria and proper utilization.	
	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.	

NC	Areas Reviewed (continued)	Findings
	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.	Six months of EHR Committee meeting minutes reviewed: • Not all services were included in reviews of EHR quality.
	The EHR copy and paste function was monitored.	
X	Appropriate quality control processes were in place for non-VA care documents, and the documents were scanned into EHRs.	• The quality control process for scanning did not address methods to ensure that scanned documents are linked to the correct EHR.
	Use and review of blood/transfusions complied with selected requirements.	
NA	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 completed and reported to the Peer Review Committee.

2. We recommended that the local observation bed policy be revised to include all required elements.

3. We recommended that processes be strengthened to ensure that the review of EHR quality includes all services.

4. We recommended that the quality control process for scanning includes methods to ensure that scanned documents are linked to the correct EHR.

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 four inpatient areas (two medical/surgical units and two intensive care units), the emergency department, three women veteran examination rooms in the urgent care area, and the physical 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. 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.	
	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	
X	The WVPM completed required annual EOC evaluations, and the facility tracked women's health-related deficiencies to closure.	Two months of EOC rounds documentation, 12 months of Women Veterans Health Committee meeting minutes, and tracking documentation reviewed: • The WVPM did not complete the required annual EOC evaluation. • The facility did not track identified women's health-related EOC deficiencies to closure.

NC	Areas Reviewed for the Women's Health Clinic (continued)	Findings
	Fire safety requirements were met.	
	Environmental safety requirements were met.	
	Infection prevention requirements were met.	
	Medication safety and security requirements were met.	
X	Patient privacy requirements were met.	• Examination and treatment rooms designated for female patients in the urgent care clinic did not have door locks.
	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.	
X	Environmental safety requirements were met.	• An After Installation Checklist was not completed for the ceiling lift in the physical therapy clinic.
	Infection prevention requirements were met.	
	Medication safety and security requirements were met.	
	Patient privacy requirements were met.	
	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.	

Recommendations

5. 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.

6. We recommended that processes be strengthened to ensure that the WVPM completes the required annual EOC evaluation.

7. We recommended that processes be strengthened to ensure that identified women's health-related EOC deficiencies are tracked to closure.

8. We recommended that processes be strengthened to ensure that examination and treatment rooms designated for female patients have door locks.

9. We recommended that an After Installation Checklist be completed for the ceiling lift in the physical therapy clinic.

Medication Management – CS Inspections

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

We reviewed relevant documents and interviewed key employees. We also reviewed the training files of all CS Coordinators and 10 CS inspectors and inspection documentation from 10 CS areas, the inpatient and outpatient pharmacies, and the emergency drug cache. The table below shows the areas reviewed for this topic. Items that did not apply to this facility are marked "NA." The facility generally met requirements. We made no recommendations.

NC	Areas Reviewed	Finding
	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), 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 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 completed 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 hospice program offered bereavement services.	
	The HPC consult contained the word “palliative” or “hospice” in the title.	
	HPC consults were submitted through the Computerized Patient Record System.	
	The PCCT responded to consults within the required timeframe and tracked consults that had not been acted upon.	
	Consult responses were attached to HPC consult requests.	
	The facility submitted the required electronic data for HPC through the VHA Support Service Center.	
	An interdisciplinary team care plan was completed for HPC inpatients within the facility’s specified timeframe.	
	HPC inpatients were assessed for pain with the frequency required by local policy.	
	HPC inpatients’ pain was managed according to the interventions included in the care plan.	
	HPC inpatients were screened for an advanced directive upon admission and according to local policy.	
	The facility complied with any additional elements required by VHA or local policy.	

Long-Term Home Oxygen Therapy

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

We reviewed relevant documents and 35 EHRs of patients enrolled in the home oxygen program (including 5 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.

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.	
X	Home oxygen program patients had active orders/prescriptions for home oxygen and were re-evaluated for home oxygen therapy annually after the first year.	• Eight of 33 EHRs (24 percent) did not contain documentation of timely annual re-evaluations.
	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.	

Recommendations

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

11. We recommended that processes be strengthened to ensure that home oxygen program patients are re-evaluated in a timely manner.

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 a selected acute care unit.

We reviewed relevant documents and six training files, and we interviewed key employees. Additionally, we reviewed the actual nursing hours per patient day for acute care unit 6S 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.[6]

We reviewed relevant documents and 27 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 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.[7]

We inspected a clinical edition construction project. Additionally, we reviewed relevant documents and 20 training records (10 contractor records and 10 employee records), and we interviewed key employees and managers. 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 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.	
	Infection control, preconstruction, interim life safety, and contractor tuberculosis risk assessments were conducted prior to project initiation.	
	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.	
	Infection Control Committee minutes documented infection surveillance activities associated with the project(s) and any interventions.	
	Construction Safety Committee minutes documented any unsafe conditions found during inspections and any follow-up actions and tracked actions to completion.	
	Contractors and designated employees received required training.	
	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.	

Facility Profile (Louisville/603) FY 2012[b]	
Type of Organization	Secondary
Complexity Level	1c-High complexity
Affiliated/Non-Affiliated	Affiliated
Total Medical Care Budget in Millions	$282.2
Number of:	
• **Unique Patients**	44,638
• **Outpatient Visits**	546,190
• **Unique Employees[c] (as of last pay period in FY 2012)**	1,543
Type and Number of Operating Beds:	
• **Hospital**	107
• **CLC**	NA
• **Mental Health**	14
Average Daily Census: (through August 2012)	
• **Hospital**	73
• **CLC**	NA
• **Mental Health**	13
Number of Community Based Outpatient Clinics	8
Location(s)/Station Number(s)	Fort Knox, KY/603GA New Albany, IN/603GB Shively, KY/603GC Dupont, KY/603GD Newburg, KY/603GE Grayson, KY/603GF Scott County, IN/603GG Carroll County, KY/603GH
VISN Number	9

[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 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	66.4	62.8	54.8	55.8	59..8	57.2
VISN	63.6	65.1	54.7	54.1	55.8	55.2
VHA	63.9	65.0	55.0	54.7	54.3	55.0

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	16.4	12.3	15.5	21.9	23.2	18.6
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: April 12, 2013

From: Director, VA Mid South Healthcare Network (10N9)

Subject: **CAP Review of the Robley Rex VA Medical Center, Louisville, KY**

To: Director, Bay Pines Office of Healthcare Inspections (54SP)

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

1. I concur with the findings and recommendations of this Office of Inspector General Combined Assessment Program Review of the Robley Rex VA Medical Center, Louisville, Kentucky, as well as the action plan developed by the facility.

2. If you have questions or require additional information from the Network, please do not hesitate to contact Joseph Schoeck, Staff Assistant to the Network Director at 615-695-2205 or me at 615-695-2206.

(original signed by:)
Vicki Kendrick

Facility Director Comments

Department of Veterans Affairs **Memorandum**

Date: April 8, 2013

From: Director, Robley Rex VA Medical Center (603/00)

Subject: **CAP Review of the Robley Rex VA Medical Center, Louisville, KY**

To: Director, VA Mid South Healthcare Network (10N9)

1. Thank you for the opportunity to review the draft report on the Combined Assessment Program for the Robley Rex VA Medical Center, Louisville, KY.

2. I have reviewed the document and concur with the recommendations. Corrective action plans have been established with planned completion dates, as detailed in the attached report.

3. I would like to express my appreciation to the OIG review team. The review team members were professional, helpful, and courteous.

(original signed by:)
Wayne L. Pfeffer, MHSA, FACHE

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 completed and reported to the Peer Review Committee.

Concur

Target date for completion: 04/01/2013

Facility response: The notification letter to the providers has been modified, to state a reply is mandatory and the means by which a reply can be sent. Follow up letters will be sent every thirty days.

Recommendation 2. We recommended that the local observation bed policy be revised to include all required elements.

Concur

Target date for completion: 02/28/2013

Facility response: The MCM 603-13-136-006 was edited to reflect VHA Directive 2009-064, Recording Observation Patients; and VHA Directive 2010-011, Standards for Emergency Department, Urgent Care Clinics, and Facility Observations Beds. Number 5-Procedures, section a and c were changed to reflect the hand-off process from provider to provider and defined who is in charge. A listing of conditions appropriate for observation and conditions not appropriate for observation patients was added as APPENDIX B to the MCM.

Recommendation 3. We recommended that processes be strengthened to ensure that the review of EHR quality includes all services.

Concur

Target date for completion: 04/01/2013

Facility response: Reviews have been increased and a spreadsheet used to verify that all Services and Specialty Clinics are reviewed at least quarterly. The spreadsheet will be reviewed by the HIM Committee and then reported to CEB.

Recommendation 4. We recommended that the quality control process for scanning includes methods to ensure that scanned documents are linked to the correct EHR.

Concur

Target date for completion: 04/01/2013

Facility response: The supervisor is using the QA review report from Vista Imaging to verify the scanner completed a 100 percent QA on documents before destruction. Scanners are to ensure that the document is linked to the correct patient, complete, legible, positioned appropriately and indexed to the note indicated on the scan slip. File Room/ROI Supervisor will do a second level random review on at least 1 percent of documents per month. The results will be reviewed in the HIM Committee and then reported to CEB.

Recommendation 5. 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: 04/19/2013 with next meeting

Facility response: Changed reporting process to include attaching all deficiencies discovered during the reporting period. This allows tracking of all EOC deficiencies within the EOC minutes from discovery to completion.

Recommendation 6. We recommended that processes be strengthened to ensure that the WVPM completes the required annual EOC evaluation.

Concur

Target date for completion: 05/31/2013

Facility response: The annual EOC evaluation will be reviewed annually in the May Women Veteran's Committee and sent to the EOC Committee for review.

Recommendation 7. We recommended that processes be strengthened to ensure that identified women's health-related EOC deficiencies are tracked to closure.

Concur

Target date for completion: The updated process has been implemented and will be monitored through July 1, 2013.

Facility response: The Women's Health Committee will identify and document all EOC deficiencies to closure within the WH Committee and in addition will send monthly committee minutes to be reviewed by EOC Committee until closure as well.

Recommendation 8. We recommended that processes be strengthened to ensure that examination and treatment rooms designated for female patients have door locks.

Concur

Target date for completion: 10/01/2013

Facility response: The hospital is in the process of rekeying the entire facility. Adding locks to exam room doors will be included in this project. The survey of rooms was completed on April 29, 2013. The addition of locks to exam room door will occur with the first phase of the project and is expected to be completed by 10/1/13.

Recommendation 9. We recommended that an After Installation Checklist be completed for the ceiling lift in the physical therapy clinic.

Concur

Target date for completion: 03/07/2013

Facility response: This was completed by Brehob of Louisville, KY.

Recommendation 10. 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: The updated process has been implemented and will be monitored through July 1, 2013.

Facility response: We have updated the Home Respiratory Care Program (HRCP) policy to reflect all activity of the program. All pertinent data is placed in a reporting tool/Dashboard. This has been added to the CEB agenda as a monthly report.

Recommendation 11. We recommended that processes be strengthened to ensure that home oxygen program patients are re-evaluated in a timely manner.

Concur

Target date for completion: The updated process has been implemented and will be monitored through July 1, 2013.

Facility response: We have updated the HRCP policy to reflect time frames/procedures dealing with expired prescriptions, prior to expiration date. Expired prescriptions are reported as an agenda item in the Monthly HRCP committee meetings. Additionally Prosthetics and Pulmonary Medicine review the expired report biweekly.

OIG Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the OIG at (202) 461-4720.
Contributors	Douglas Henao, MS,RD, Team Leader Charles Cook, MHA David Griffith, RN, FAIHQ, Karen McGoff-Yost, LCSW, MSW Carol Torczon, MSN, ACNP Richard Ellison, Special Agent, Office of Investigations

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U.S. House of Representatives: Andy Barr, S. Brett Guthrie, Thomas Massie, Harold Rogers, Ed Whitfield, John A. Yarmuth

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.
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