Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 13-00888-203

Combined Assessment Program Review of the VA Southern Nevada Healthcare System Las Vegas, Nevada

May 30, 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
CS	controlled substances
EHR	electronic health record
EOC	environment of care
facility	VA Southern Nevada Healthcare System
FY	fiscal year
HPC	hospice and palliative care
MH	mental health
NA	not applicable
NC	noncompliant
OIG	Office of Inspector General
PCC	primary care clinic
PCCT	Palliative Care Consult Team
PR	peer review
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 March 18, 2013.

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

- Environment of Care
- Long-Term Home Oxygen Therapy

The facility's reported accomplishments were the new facility and clinic activation, the secure messaging program, and patient-centered care initiatives at the new facility.

Recommendations: We made recommendations in the following five activities:

Quality Management: Ensure that actions from peer reviews are consistently completed and reported to the Peer Review Committee, that compliance with the recently implemented observation bed use policy is monitored, and that the results of non-VA purchased diagnostic tests are consistently scanned into electronic health records.

Medication Management – Controlled Substances Inspections: Initiate actions to address identified deficiencies in the primary care clinic pharmacies, and correct all deficiencies identified during annual physical security inspections. Develop instructions for inspecting automated dispensing machines that include all Veterans Health Administration requirements. Ensure that inspectors receive annual updates and/or refresher training, that the coordinator only conducts occasional inspections, and that a sufficient number of inspectors are appointed to conduct the monthly inspections.

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

Nurse Staffing: Fully implement the nurse staffing methodology.

Preventable Pulmonary Embolism: Initiate protected peer review for the one identified patient, and complete any recommended review actions.

Comments

The Veterans Integrated Service Network and Facility Directors agreed with the Combined Assessment Program review findings and recommendations and provided acceptable improvement plans. (See Appendixes C and D, pages 17–22, for the full text of the Directors' comments.) We will follow up on the planned actions until they are completed.

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

Objectives and Scope

Objectives

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

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

Scope

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

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

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

The review covered facility operations for FY 2012 and FY 2013 through March 18, 2013, and was done in accordance with OIG standard operating procedures for CAP reviews. We also asked the facility to provide the status on the recommendations we made in our previous CAP report (*Combined Assessment Program Review of the VA Southern Nevada Healthcare System, Las Vegas, Nevada,* Report No. 09-03613-74, January 27, 2010).

During this review, we presented crime awareness briefings for 230 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 536 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

New Facility and Clinic Activation

On August 6, 2012, VA Secretary Eric K. Shinseki dedicated the new 1 million square foot facility that will include 90 acute and 120 CLC inpatient beds. The new facility is projected to meet an annual demand of approximately 800,000 ambulatory care encounters. As of January 2013, all ambulatory care services were open. The next phase, with a target date of July 2013, will include opening the inpatient units and the operating rooms. The final phase includes the planning and construction of the administration and education buildings and the expansion of the emergency department.

Also in August 2012, the facility's Psychosocial Rehabilitation and Recovery Center program was successfully relocated to a new facility. The program received full accreditation without any recommendations from the Commission on Accreditation of Rehabilitation Facilities. Beginning in late 2011 through 2012, the facility also opened 4 new 25,000 square foot PCCs in the Las Vegas area. Each PCC offers medicine, surgery subspecialties, MH, and support services.

Secure Messaging Program

In September 2011, to ensure success of the secure messaging program, the facility implemented the Secure Messaging Committee. The committee focused on the use of secure messaging to: (1) increase access in primary care, (2) renew medications, and (3) send appointment requests to and assist with phone calls in the PCCs. In October 2011, the program started with approximately 300 patients. By the end of FY 2012, more than 6,161 patients were using the program through My Health***e***Vet[a] and more than 10,137 secure messages had been completed for all primary care, outpatient specialty, and surgical clinics.

[a] My Health*e*Vet is VA's secure online personal health record for veterans, service members, and their families and caregivers.

Patient-Centered Care Initiatives

The facility received funding from the Office of Patient-Centered Care and Cultural Transformation to promote innovative initiatives for patient-centered care. In 2012, the facility developed five PCC initiatives and further elevated its new facility into a truly "healing environment" by using Center for Innovation funds. In addition to the initiatives that are in progress, the funds also helped purchase artwork, artificial plants, massage tables, electronic devices (Kindle Fires), and a music system to further enhance a healing environment.

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 PR process were reported to the PR Committee.	Six months of PR Committee meeting minutes reviewed: • Of the 10 actions expected to be completed, 3 were not reported to the PR 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.	• Until March 2013, the facility did not have a policy regarding the use of observation beds.
	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.	
	The cardiopulmonary resuscitation review policy and processes complied with requirements for reviews of episodes of care where resuscitation was attempted.	
	There was an EHR quality review committee, and the review process complied with selected requirements.	
	The EHR copy and paste function was monitored.	

NC	Areas Reviewed (continued)	Findings
X	Appropriate quality control processes were in place for non-VA care documents, and the documents were scanned into EHRs.	Thirty EHRs of patients who had non-VA purchased diagnostic tests reviewed: • Twenty-three test results (77 percent) were not scanned or transcribed into the EHRs.
	Use and review of blood/transfusions complied with selected requirements.	
	CLC minimum data set forms were transmitted to the data center monthly.	
	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 PRs are consistently completed and reported to the PR Committee.

2. We recommended that the facility monitor compliance with the recently implemented observation bed use policy.

3. We recommended that processes be strengthened to ensure that the results of non-VA purchased diagnostic tests are consistently scanned into EHRs.

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 Mike O'Callaghan Federal Hospital,[b] we inspected the intensive care, medical/surgical, and MH inpatient units and the emergency department. At the facility, we inspected the physical therapy, kinesiotherapy, and occupational therapy rehabilitation clinics. We also inspected the Southwest, Southeast, Northeast, and Northwest PCCs in the Las Vegas area, including the women's health clinic. 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 the 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.	

[b] The facility has 57 hospital beds at this hospital as part of a sharing agreement with the Department of Defense's 99th Medical Group at Nellis Air Forces Base in North Las Vegas.

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.	
	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 the CS Coordinator and eight CS inspectors and inspection documentation from eight CS areas (PCCs and PCC pharmacies), the main pharmacy (facility), 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: • Deficiencies identified in the PCC pharmacies in 2012 had not yet been corrected, and there were no action plans.
X	Instructions for inspecting automated dispensing machines were documented, included all required elements, and were followed.	• There were no instructions for inspecting automated dispensing machines.
	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.	
X	CS inspectors were appointed in writing, completed required certification and training, and were free from conflicts of interest.	Appointments, certifications, and training records reviewed: • Four CS inspectors did not receive annual updates and/or refresher training.
	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.	

NC	Areas Reviewed (continued)	Findings
X	The facility complied with any additional elements required by VHA or local policy.	Documentation of inspections conducted from July 2012 through January 2013 reviewed: • The CS Coordinator routinely conducted all inspections every other month rather than occasionally. • The facility did not appear to have sufficient inspectors for the monthly inspections.

Recommendations

4. We recommended that managers initiate actions to address identified deficiencies in the PCC pharmacies and that processes be strengthened to ensure that all deficiencies identified during annual physical security surveys are corrected.

5. We recommended that the facility develop instructions for inspecting automated dispensing machines that include all VHA requirements and that compliance be monitored.

6. We recommended that processes be strengthened to ensure that CS inspectors receive annual updates and/or refresher training.

7. We recommended that processes be strengthened to ensure that the CS Coordinator only performs occasional inspections and that a sufficient number of CS inspectors are appointed to conduct the monthly inspections.

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, and 25 employee training records (6 HPC staff records and 19 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 19 non-HPC staff, there was no evidence that 7 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.	
NA	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.	
NA	An interdisciplinary team care plan was completed for HPC inpatients within the facility's specified timeframe.	
NA	HPC inpatients were assessed for pain with the frequency required by local policy.	
NA	HPC inpatients' pain was managed according to the interventions included in the care plan.	
NA	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

8. We recommended that processes be strengthened to ensure that all 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 5 patients deemed to be high risk), and we interviewed key employees. The table below shows the areas reviewed for this topic. Items that did not apply to this facility are marked "NA." The facility generally met requirements. We made no recommendations.

NC	Areas Reviewed	Findings
	There was a local policy to reduce the fire hazards of smoking associated with oxygen treatment.	
	The Chief of Staff reviewed home respiratory care program activities at least quarterly.	
	The facility had established a home respiratory care team.	
	Contracts for oxygen delivery contained all required elements and were monitored quarterly.	
	Home oxygen program patients had active orders/prescriptions for home oxygen and were re-evaluated for home oxygen therapy annually after the first year.	
	Patients identified as high risk received hazards education at least every 6 months after initial delivery.	
	NC high-risk patients were identified and referred to a multidisciplinary clinical committee for review.	
	The facility complied with any additional elements required by VHA or local policy.	

Nurse Staffing

The purpose of this review was to determine the extent to which the facility implemented the staffing methodology for nursing personnel and to evaluate nurse staffing on two selected units (acute care and long-term care).[6]

We reviewed relevant documents, and we interviewed key employees. The table below shows the areas reviewed for this topic. The area marked as NC needed improvement. Items that did not apply to this facility are marked "NA."

NC	Areas Reviewed	Findings
	The unit-based expert panels followed the required processes.	
	The facility expert panel followed the required processes and included all required members.	
	Members of the expert panels completed the required training.	
X	The facility completed the required steps to develop a nurse staffing methodology by September 30, 2011.	• The facility had not fully implemented the staffing methodology.
	The selected units' actual nursing hours per patient day met or exceeded the target nursing hours per patient day.	
	The facility complied with any additional elements required by VHA or local policy.	

Recommendation

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

Preventable Pulmonary Embolism

The purpose of this review was to evaluate the care provided to patients who were treated at the facility and developed potentially preventable pulmonary embolism.[7]

We reviewed relevant documents and 25 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. The area marked as NC needed improvement. Items that did not apply to this facility are marked "NA."

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

Recommendation

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

[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.

Facility Profile (Las Vegas/593) FY 2012[d]	
Type of Organization	Secondary
Complexity Level	2-Medium complexity
Affiliated/Non-Affiliated	Affiliated
Total Medical Care Budget in Millions	$373.7
Number of:	
• **Unique Patients**	45,516
• **Outpatient Visits**	552,800
• **Unique Employees**[e]	1,378
Type and Number of Operating Beds: (through August 2012)	
• **Hospital**	57
• **CLC**	NA
• **MH**	14
Average Daily Census: (through August 2012)	
• **Hospital**	47
• **CLC**	NA
• **MH**	10.47
Number of Community Based Outpatient Clinics	2
Location(s)/Station Number(s)	Henderson/593GB Pahrump/593GC
VISN Number	22

[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	59.3	61.1	49.7	46.5	47.3	45.3
VISN	60.7	61.9	51.8	52.6	53.4	50.7
VHA	63.9	65.0	55.0	54.7	54.3	55.0

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: April 23, 2013

From: Director, Desert Pacific Healthcare Network (10N22)

Subject: **CAP Review of the VA Southern Nevada Healthcare System, Las Vegas, NV**

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

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

1. I concur with the findings and recommendations in the report of the CAP Review of the VA Southern Nevada Healthcare System, Las Vegas, NV.

2. If you have any questions regarding our responses and actions to the recommendations in the draft report, please contact me at (562) 826-5963.

Stan Johnson

Stan Johnson, MHA, FACHE

Attachment

Facility Director Comments

Department of Veterans Affairs **Memorandum**

Date: April 19, 2013

From: Director, VA Southern Nevada Healthcare System (593/00)

Subject: **CAP Review of the VA Southern Nevada Healthcare System, Las Vegas, NV**

To: Director, Desert Pacific Healthcare Network (10N22)

1. I appreciate the opportunity to provide comments to the draft report of the Combined Assessment Program (CAP) review of the VA Southern Nevada Healthcare System (VASNHS), Las Vegas, NV, during the week of March 18–21, 2013. I have discussed the findings and recommendations with the senior leadership at VASNHS.

2. In brief, I concur with all of the recommendations in the report. The staff at VASNHS has already begun to implement improvement actions.

3. If you have any questions, please contact my office at (702) 791-9010.

(original signed by:)
John B. Bright
Director

Comments to OIG's Report

The following Director's comments are submitted in response to the recommendations in the OIG report:

OIG Recommendations

Recommendation 1. We recommended that processes be strengthened to ensure that actions from PRs are consistently completed and reported to the PR Committee.

Concur with recommended improvement actions.

Target date for completion: May 23, 2013

Facility response: The Peer Review Committee (PRC) changed the frequency of their meetings to bi-monthly on 2/12/13 to ensure timeliness of review and follow-up. An open action item tracking grid was created to monitor follow-up. This grid was implemented at the 3/28/13 PRC meeting. Two of the outstanding actions were closed on 4/9/13 and 4/25/13, and the third action is expected to be closed no later than 5/25/13.

Recommendation 2. We recommended that the facility monitor compliance with the recently implemented observation bed use policy.

Concur with recommended improvement actions.

Target date for completion: August 30, 2013

Facility response: The Utilization Management (UM) Manager/staff provided in-service training on MCM 11-25 *Emergency Department and Facility Observations* from 3/26/13–4/19/13 to the clinical staff involved with observation admissions. The UM staff will monitor 100% of observation admissions for three months to determine compliance with MCM 11-25. The UM Manager will report the results of the audits to the UM Committee during their quarterly meeting. The results reported will be included in the UM Committee Minutes.

Recommendation 3. We recommended that processes be strengthened to ensure that the results of non-VA purchased diagnostic tests are consistently scanned into EHRs.

Concur with recommended improvement actions.

Target date for completion: October 31, 2013

Facility response: The Chief of HIMS will develop a consistent process to ensure fee based diagnostic test results are scanned into the electronic health record. HIMS will monitor compliance with the process for two quarters in FY 13 to show improvement until a compliance rate of 90% is achieved.

Recommendation 4. We recommended that managers initiate actions to address identified deficiencies in the PCC pharmacies and that processes be strengthened to ensure that all deficiencies identified during annual physical security surveys are corrected.

Concur with recommended improvement actions.

Target date for completion: June 16, 2013

Facility response: The status of previously identified deficiencies will be reported to Environment of Care (EOC) in 4/18/13. All deficiencies have been corrected except for the NW PCC Pharmacy deficiency. A work order was submitted for repair of the alarm deficiency. Physical security inspections will be reported to the Controlled Substance Coordinator (CSC) and EOC to assure action plans are in place and follow through completed.

Recommendation 5. We recommended that the facility develop instructions for inspecting automated dispensing machines that include all VHA requirements and that compliance be monitored.

Concur with recommended improvement actions.

Target date for completion: April 30, 2013

Facility response: An Instruction check sheet for use by controlled substance inspectors was developed to meet VHA requirements for inspection of the pyxis systems, main vault, and vaults at the primary care clinics. The Controlled Substance Coordinator (CSC) and/or CSC alternate will monitor compliance by monthly review of inspection reports. The outcome of this review will be included in the monthly summary to the Director.

Recommendation 6. We recommended that processes be strengthened to ensure that CS inspectors receive annual updates and/or refresher training.

Concur with recommended improvement actions.

Target date for completion: May 31, 2013

Facility response: The existing CS inspectors received their annual training in March 2013. The newly appointed CS Inspectors are in the process of completing their training/certification through the TMS "Controlled Substance Inspector Certification Course." The anticipated date of completion for this training is 5/10/13. After initial certification training, the inspectors are required to complete the CS Inspectors annual refresher training course that is in the process of development and will be placed in TMS. The CSC will disseminate any updates to all CS inspectors as received.

Recommendation 7. We recommended that processes be strengthened to ensure that the CS Coordinator only performs occasional inspections and that a sufficient number of CS inspectors are appointed to conduct the monthly inspections.

Concur with recommended improvement actions.

Target date for completion: October 1, 2013

Facility response: Twelve additional CS inspectors were appointed on 3/8/13 to conduct monthly inspections. The increase in inspectors will ensure that the CS Coordinator only performs occasional inspections and that a sufficient number of CS inspectors are available to conduct the monthly inspections. We will monitor monthly inspections for two quarters to ensure compliance with the CS inspections requirements.

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

Concur with recommended improvement actions.

Target date for completion: July 1, 2013

Facility response: The following has been implemented to ensure that all non-HPC staff receive end-of-life training:

The video "Leading the Way VA Palliative Care" was assigned in TMS as a mandatory viewing for all new employees during new employee orientation beginning 3/18/13. All non-HPC staff was assigned this mandatory training in TMS on 4/16/13 and are required to complete it by 7/1/13. The groups required to take this training include the following:

Providers and residents, nurses, chaplains, social workers, nurse's aides, counselors, psychologists, volunteers, emergency medical technicians, personnel support assistants/receptionists, housekeeping staff assigned to clinical settings, radiology staff, respiratory therapy, occupational therapy, physical therapy, speech therapy, transport staff, laboratory staff, culinary personnel, dieticians, prosthetic department staff, dentists and hygienists. Compliance will be monitored in TMS.

Recommendation 9. We recommended that the facility fully implement the nurse staffing methodology.

Concur with recommended improvement actions.

Target date for completion: November 31, 2013

Facility response: Upon staff relocation to the new facility, the Unit-Based Expert Panels (UBEP) for each unit will be reestablished and staff will be educated in TMS training Module *Staffing Methodology for VHA Nursing Personnel.* The UBEP will meet with the unit Nurse Manager to review their current staffing plan. The UBEP and Nurse

Manager will utilize the Nursing Hours Per Patient Day (NHPPD) to assess and reassess workloads, allowing for completion of required direct care responsibilities. A Facility Based Expert Panel (FBEP) will be initiated. Once an annual review of the unit-based panel package is approved, it will be forwarded for Nurse Executive review and submission to the Medical Executive and Executive Leadership Boards.

The planned timeline for completion includes the following:

The Inpatient Mental Health Unit moved to the new facility on 4/15/13. A time motion study will be completed by 7/31/13. This will give the staff a chance to adjust to their new environment and give us more accurate data to determine their staffing needs. The anticipated move of the Inpatient Medicine Unit is 6/1/13. A time motion study will be completed by 8/31/13. The staffing methodology NHPPD reassessment for the Inpatient Mental Health and Medicine Units will be implemented by 9/30/13. The anticipated move of the ICU/SDU and Inpatient Surgery is 7/1/13. A time motion study will be completed by 10/31/13. The staffing methodology NHPPD reassessment for the ICU/SDU and Inpatient Surgery will be implemented by 11/31/13.

Recommendation 10. We recommended that managers initiate protected PR for the one identified patient and complete any recommended review actions.

Concur with recommended improvement actions.

Target date for completion: 4/25/2013

Facility response: One patient was identified as having a delayed diagnosis of pulmonary embolism. The initial Protected Peer Review (PPR) was assigned, completed, and returned to Risk Management on 4/12/2013. The case will be presented at the Peer Review Committee (PRC) on 4/25/13 and closure is anticipated on this date.

OIG Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the OIG at (202) 461-4720.
Onsite Contributors	Kathleen Shimoda, RN, Team Leader Daisy Arugay, MT Keyla Gammarano, RN, MHA Yoonhee Kim, Pharm.D Simonette Reyes, RN Greg Fitzgerald, Special Agent, Office of Investigations
Other Contributors	Elizabeth Bullock Shirley Carlile, BA Paula Chapman, CTRS Lin Clegg, PhD Marnette Dhooghe, MS Matt Frazier, MPH Jeff Joppie, BS Karen McGoff-Yost, MSW, LCSW Jackelinne Melendez, MPA Victor Rhee, MHS Julie Watrous, RN, MS Jarvis Yu, MS

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U.S. Senate: Dean Heller, Harry Reid
U.S. House of Representatives: Joe Heck, Steven Horsford, Dina Titus

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

Endnotes

[1] References used for this topic included:
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