
**Department of Veterans Affairs**
**Office of Inspector General**

**Office of Healthcare Inspections**

**Report No. 13-00274-224**

# Combined Assessment Program Review of the VA Pacific Islands Health Care System Honolulu, Hawaii

**June 19, 2013**

**Washington, DC 20420**

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

# Glossary

| | |
|---|---|
| CAP | Combined Assessment Program |
| CLC | community living center |
| CS | controlled substances |
| EHR | electronic health record |
| EOC | environment of care |
| facility | VA Pacific Islands Health Care System |
| FPPE | Focused Professional Practice Evaluation |
| FY | fiscal year |
| HPC | hospice and palliative care |
| MH | mental health |
| NA | not applicable |
| NC | noncompliant |
| OIG | Office of Inspector General |
| PCCT | Palliative Care Consult Team |
| PSB | Professional Standards Board |
| QM | quality management |
| RRTP | residential rehabilitation treatment program |
| VHA | Veterans Health Administration |
| VISN | Veterans Integrated Service Network |

# 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 March 18, 2013.

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

- Environment of Care
- Coordination of Care – Hospice and Palliative Care
- Preventable Pulmonary Embolism
- Mental Health Residential Rehabilitation Treatment Program
- Continuity of Care

The facility's reported accomplishment was the creation of the VA Pacific Islands Call Center to enhance veterans' ability to contact the facility. The call center is one of the few VA call centers to have a pharmacy technician available to assist veterans with their medication refills and the only VA call center in the nation to have a veterans benefits representative to address benefit questions and concerns.

**Recommendations:** We made recommendations in the following four activities:

*Quality Management:* Consistently report results of Focused Professional Practice Evaluations for newly hired licensed independent practitioners to the Professional Standards Board.

*Medication Management – Controlled Substances Inspections:* Ensure controlled substances inspections are randomly scheduled with no distinguishable patterns, and monitor compliance.

*Long-Term Home Oxygen Therapy:* Re-evaluate home oxygen program patients for home oxygen therapy annually after the first year.

*Nurse Staffing:* Monitor the staffing methodology that was implemented in November 2012.

## Comments

The Veterans Integrated Service Network Director and Acting Facility Director agreed with the Combined Assessment Program review findings and recommendations and provided acceptable improvement plans. (See Appendixes C and D, pages 17–20, 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, conversed with managers and employees, and reviewed clinical and administrative records. The review covered the following nine activities:

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

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 22, 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 Pacific Islands Health Care System, Honolulu, Hawaii,* Report No. 09-01643-170, July 23, 2009).

During this review, we presented crime awareness briefings for 181 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 171 responded. We shared summarized 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 Accomplishment

## VA Pacific Islands Call Center

In order to improve telephone functionality and access to care, the facility chartered a process action team to address the dropped call rate and number of unreturned telephone calls. The team created a "Voice of the Veteran" survey and conducted interviews with veterans to assess the difficulties they were having in contacting the facility via the telephone system. When the project was initiated, the dropped call rate was 29 percent with an average of 130 unreturned phone calls per day.

Based upon the team's findings, the facility created the VA Pacific Islands Call Center. The call center is staffed with a manager, pharmacist, pharmacy technician, five medical support assistants, two telephone operators, three registered nurses, and a veterans benefits representative. Since the initiation of the call center, the dropped call rate has decreased to 6 percent with less than 10 unreturned telephone calls per day. Additionally, calls are being answered within 30 to 60 seconds. The call center is one of the few VA call centers to have a pharmacy technician available to assist veterans with their medication refills and the only VA call center in the nation to have a veterans benefits representative to address benefit questions and concerns.

# 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 conversed with 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 area 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 | FPPEs for newly hired licensed independent practitioners complied with selected requirements. | Eight profiles reviewed:<br>• Results of seven of the eight FPPEs completed were not reported to the PSB. |
| NA | Local policy for the use of observation beds complied with selected requirements. | |
| NA | Data regarding appropriateness of observation bed use was gathered, and conversions to acute admissions were less than 30 percent. | |
| NA | Staff performed continuing stay reviews on at least 75 percent of patients in acute beds. | |
| NA | Appropriate processes were in place to prevent incidents of surgical items being retained in a patient following surgery. | |
| | 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 |
|---|---|---|
| | Appropriate quality control processes were in place for non-VA care documents, and the documents were scanned into EHRs. | |
| NA | 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. | |
| | 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. | |

## Recommendation

**1.** We recommended that processes be strengthened to ensure that results of FPPEs for newly hired licensed independent practitioners are consistently reported to the PSB.

## EOC

The purpose of this review was to determine whether the facility maintained a clean and safe health care environment in accordance with applicable requirements.[2]

We inspected the 3B2 inpatient MH unit, the ambulatory care clinic, the urgent care clinic, the women's health clinic, the physical therapy and occupational therapy clinic, and the CLC. Additionally, we reviewed relevant documents and conversed with key employees and managers. The table below shows the areas reviewed for this topic. Items that did not apply to this facility are marked "NA." The facility generally met requirements. We made no recommendations.

| NC | Areas Reviewed for General EOC | Findings |
|---|---|---|
| | EOC Committee minutes reflected sufficient detail regarding identified deficiencies, corrective actions taken, and tracking of corrective actions to closure. | |
| | An infection prevention risk assessment was conducted, and actions were implemented to address high-risk areas. | |
| | Infection Prevention/Control Committee minutes documented discussion of identified problem areas and follow-up on implemented actions and included analysis of surveillance activities and data. | |
| | The facility had a policy that detailed cleaning of equipment between patients. | |
| | Patient care areas were clean. | |
| | Fire safety requirements were met. | |
| | Environmental safety requirements were met. | |
| | Infection prevention requirements were met. | |
| | Medication safety and security requirements were met. | |
| | Sensitive patient information was protected, and patient privacy requirements were met. | |
| | The facility complied with any additional elements required by VHA, local policy, or other regulatory standards. | |
| | **Areas Reviewed for the Women's Health Clinic** | |
| | The Women Veterans Program Manager completed required annual EOC evaluations, and the facility tracked women's health-related deficiencies to closure. | |
| | Fire safety requirements were met. | |
| | Environmental safety requirements were met. | |
| | Infection prevention requirements were met. | |
| | Medication safety and security requirements were met. | |

| NC | Areas Reviewed for the Women's Health Clinic (continued) | Findings |
|---|---|---|
| | Patient privacy requirements were met. | |
| | The facility complied with any additional elements required by VHA, local policy, or other regulatory standards. | |
| | **Areas Reviewed for Physical Medicine and Rehabilitation Therapy Clinics** | |
| | Fire safety requirements were met. | |
| | Environmental safety requirements were met. | |
| | Infection prevention requirements were met. | |
| | Medication safety and security requirements were met. | |
| | Patient privacy requirements were met. | |
| | The facility complied with any additional elements required by VHA, local policy, or other regulatory standards. | |

## Medication Management – CS Inspections

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

We reviewed relevant documents and conversed with key employees. We also reviewed the training files of all CS Coordinators and 10 CS inspectors and inspection documentation from two CS areas, the inpatient and outpatient pharmacies, and the emergency drug cache. 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 |
|---|---|---|
| | 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. | |
| X | Non-pharmacy areas with CS were inspected in accordance with VHA requirements, and inspections included all required elements. | Documentation of two CS areas inspected during the past 6 months reviewed:<br>• In one of the areas, distinguishable patterns were identified, and most inspections were performed on the second Tuesday of the month. |
| | 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. | |

### Recommendation

**2.** We recommended that processes be strengthened to ensure that inspections are randomly scheduled with no distinguishable patterns and that compliance be monitored.

## Coordination of Care – HPC

The purpose of this review was to determine whether the facility complied with selected requirements related to HPC, including PCCT, consults, and inpatient services.[4]

We reviewed relevant documents, 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 conversed with key employees. The table below shows the areas reviewed for this topic. Items that did not apply to this facility are marked "NA." The facility generally met requirements. We made no recommendations.

| NC | Areas Reviewed | Findings |
|---|---|---|
| | A PCCT was in place and had the dedicated staff required. | |
| | The PCCT actively sought patients appropriate for HPC. | |
| | The PCCT offered end-of-life training. | |
| | HPC staff and selected non-HPC staff had end-of-life training. | |
| | The facility had a VA liaison with community hospice programs. | |
| | The PCCT promoted patient choice of location for hospice care. | |
| | The CLC-based hospice program offered bereavement services. | |
| | The HPC consult contained the word "palliative" or "hospice" in the title. | |
| | HPC consults were submitted through the Computerized Patient Record System. | |
| | The PCCT responded to consults within the required timeframe and tracked consults that had not been acted upon. | |
| | Consult responses were attached to HPC consult requests. | |
| | The facility submitted the required electronic data for HPC through the VHA Support Service Center. | |
| | An interdisciplinary team care plan was completed for HPC inpatients within the facility's specified timeframe. | |
| | HPC inpatients were assessed for pain with the frequency required by local policy. | |
| | HPC inpatients' pain was managed according to the interventions included in the care plan. | |
| | HPC inpatients were screened for an advanced directive upon admission and according to local policy. | |
| | The facility complied with any additional elements required by VHA or local policy. | |

## Long-Term Home Oxygen Therapy

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

We reviewed relevant documents and 35 EHRs of patients enrolled in the home oxygen program, and we conversed with key employees. The table below shows the areas reviewed for this topic. The area marked as NC needed improvement. Items that did not apply to this facility are marked "NA."

| NC | Areas Reviewed | Findings |
|---|---|---|
| | There was a local policy to reduce the fire hazards of smoking associated with oxygen treatment. | |
| | 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. | |
| 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. | • Eighteen EHRs (51 percent) contained no documentation of a re-evaluation after the first year. |
| NA | Patients identified as high risk received hazards education at least every 6 months after initial delivery. | |
| NA | NC high-risk patients were identified and referred to a multidisciplinary clinical committee for review. | |
| | The facility complied with any additional elements required by VHA or local policy. | |

### Recommendation

**3.** We recommended that processes be strengthened to ensure that home oxygen program patients are re-evaluated for home oxygen therapy annually after the first year.

## 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 conversed with 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. | • Expert panels were not convened until November 23, 2012. |
| | 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

**4.** We recommended that nursing managers monitor the staffing methodology that was implemented in November 2012.

## 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 six EHRs of patients with confirmed diagnoses of pulmonary embolism[a] January 1–June 30, 2012. We also conversed with key employees. The table below shows the areas reviewed for this topic. Items that did not apply to this facility are marked "NA." The facility generally met requirements. We made no recommendations.

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

[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.

## MH RRTP

The purpose of this review was to determine whether the facility's Post-Traumatic Stress Disorder RRTP complied with selected EOC requirements.[8]

We reviewed relevant documents, inspected one unit, and conversed with 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 |
|---|---|---|
| | The residential environment was clean and in good repair. | |
| NA | Appropriate fire extinguishers were available near grease producing cooking devices. | |
| | There were policies/procedures that addressed safe medication management and contraband detection. | |
| | Monthly MH RRTP self-inspections were conducted, documented, and included all required elements, work orders were submitted for items needing repair, and any identified deficiencies were corrected. | |
| | Contraband inspections, staff rounds of all public spaces, daily bed checks, and resident room inspections for unsecured medications were conducted and documented. | |
| | Written agreements acknowledging resident responsibility for medication security were in place. | |
| | The main point(s) of entry had keyless entry and closed circuit television monitoring, and all other doors were locked to the outside and alarmed. | |
| | Closed circuit television monitors with recording capability were installed in public areas but not in treatment areas or private spaces, and there was signage alerting veterans and visitors that they were being recorded. | |
| | There was a process for responding to behavioral health and medical emergencies, and staff were able to articulate the process(es). | |
| NA | In mixed gender units, women veterans' rooms were equipped with keyless entry or door locks, and bathrooms were equipped with door locks. | |

| NC | Areas Reviewed (continued) | Findings |
|---|---|---|
| | Medications in resident rooms were secured. | |
| | The facility complied with any additional elements required by VHA or local policy. | |

## Continuity of Care

The purpose of this review was to evaluate whether information from patients' community or Tripler Army Medical Center hospitalizations at VA expense was available to facility providers.[9] Such communication is essential to continuity of care and optimal patient outcomes.

We reviewed relevant documents and the EHRs of 30 patients who had been hospitalized at VA expense in the local community or at Tripler Army Medical Center during September and October 2012, and we conversed with 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 |
|---|---|---|
| | Clinical information was available to the primary care team for the clinic visit subsequent to the hospitalization. | |
| | The facility complied with any additional elements required by VHA or local policy. | |

| Facility Profile (Honolulu/459) FY 2012[b] | |
|---|---|
| **Type of Organization** | Secondary |
| **Complexity Level** | 3-Low complexity |
| **Affiliated/Non-Affiliated** | Affiliated |
| **Total Medical Care Budget in Millions** | $222.2 |
| **Number of:** | |
| • **Unique Patients** | 28,345 |
| • **Outpatient Visits** | 226,680 |
| • **Unique Employees[c] (as of last pay period in FY 2012)** | 697 |
| **Type and Number of Operating Beds:** | |
| • **Hospital** | 16 |
| • **CLC** | 60 |
| • **MH** | 16 |
| **Average Daily Census: (through August 2012)** | |
| • **Hospital** | 9 |
| • **CLC** | 48 |
| • **MH** | 11 |
| **Number of Community Based Outpatient Clinics** | 6 |
| **Location(s)/Station Number(s)** | Maui, HI/459GA<br>Hilo, HI/459GB<br>Kona, HI/459GC<br>Kauai, HI/459GD<br>Agna Heights, Guam/459GE<br>Pago Pago, American Samoa/459GF |
| **VISN Number** | 21 |

[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 | * | * | 57.7 | 43.3 | 53.3 | 52.0 |
| VISN | 70.1 | 70.3 | 58.1 | 55.8 | 57.4 | 59.1 |
| VHA | 63.9 | 65.0 | 55.0 | 54.7 | 54.3 | 55.0 |

* A score is not reported because there were fewer than 30 responses.

# VISN Director Comments

**Department of Veterans Affairs** **Memorandum**

**Date:** June 5, 2013

**From:** Director, Sierra Pacific Network (10N21)

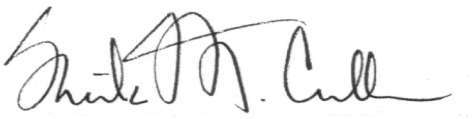
**Subject:** **CAP Review of the VA Pacific Islands Health Care System, Honolulu, HI**

**To:** Director, San Diego Office of Healthcare Inspections (54SD)

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

Thank you for the opportunity to review the draft OIG CAP report from your recent site visit conducted March 19–21, 2013. Attached you will find the action plan developed by the facility in response to the four recommendations received.

If you have any questions please contact, Terry Sanders, Deputy Quality Manager for Network 21 at (707) 562-8370.



Sheila M. Cullen

# Acting Facility Director Comments

**Department of Veterans Affairs** **Memorandum**

**Date:** June 3, 2013

**From:** Acting Director, VA Pacific Islands Health Care System (459/00)

**Subject:** **CAP Review of the VA Pacific Islands Health Care System, Honolulu, HI**

**To:** Director, Sierra Pacific Network (10N21)

Enclosed is the VA Pacific Island Health Care System after action report. Responses to the four CAP Review of the VAPIHCS recommendations which resulted from the survey conducted March 19–21, 2013 are included.

If you have any questions pertaining to this after action report, please contact Jacqueline R. White, Chief Quality Management at telephone (808) 433-0683.

Sincerely,

William F. Dubbs, M.D.

# 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 results of FPPEs for newly hired licensed independent practitioners are consistently reported to the PSB.

Concur

Target date for completion: August 7, 2013

Facility response: Standing FPPE agenda items will be created and remain on all future PSB agendas. All Associate Chief of Staff (ACOS) members will be required to report to the PSB the 1st day a new FPPE has been initiated. The ACOS will also indicate the anticipated end of the FPPE and the expected presentation to the PSB (next available PSB following the FPPE completion. A tracking log will be created with all practitioners under FPPE listing the beginning, end and expected presentation date. ACOSs will also be asked to report any adjustments to FPPE dates to ensure PSB is looking for a report when indicated. This process ensure 100% awareness and tracking by PSB.

**Recommendation 2.** We recommended that processes be strengthened to ensure that inspections are randomly scheduled with no distinguishable patterns and that compliance be monitored.

Concur

Target date for completion: August 31, 2013

Facility response: The Controlled Substance Coordinator developed a new controlled inspection roster so that there are no distinguishable patterns and has put it into place. This process will be reviewed by the Chief of Pharmacy and Alternate Controlled Substance Coordinator on a quarterly basis to review the dates and times Controlled Substance Reports were conducted to see if there are any distinguishable patterns to the surveys conducted. Their findings will be included in the Quarterly Controlled Substance Report to the Director.

**Recommendation 3.** We recommended that processes be strengthened to ensure that home oxygen program patients are re-evaluated for home oxygen therapy annually after the first year.

Concur

Target date for completion: August 31, 2013

Facility response: All prescribing providers were re-educated by the Chair of the Oxygen Committee indicating that expired oxygen prescriptions must be renewed timely and when they are not this could jeopardize the continuation of the oxygen for the Veteran. On a monthly basis, the Chief of Prosthetics reviews the oxygen list for oxygen prescriptions that will be expiring the following month. A list of upcoming expiring oxygen prescriptions is provided to prescribing providers, the chair of the Oxygen Committee, QMS, and the Primary Care Leadership if prescriptions are not renewed on time. Quarterly, the Chair of the Oxygen Committee presents a report on oxygen renewal compliance to the Executive Committee of the Medical Staff. In addition, Oxygen Committee minutes are submitted to the Chief of Staff through the ACOS PC and Committee Chairperson for review and sign off.

**Recommendation 4.** We recommended that nursing managers monitor the staffing methodology that was implemented in November 2012.

Concur

Target date for completion: August 31, 2013

Facility response: The CLC Nurse Manager tracks CLC Nurse Staffing patterns utilizing tools provided by the National Staffing Methodology initiative and other information from the DSS database. During FY 2013, this data has been tracked on a monthly basis. This information is reported monthly to the ADPCS/NE and the Unit-Based Staffing Methodology Expert Panel. Suggested next steps are: 1) Facility-Based Staffing Methodology Expert Panel. 2) A Meeting will be convened of the Unit-Based Staffing Methodology Expert Panel in July to analyze the data and provide input to the CLC Staffing Annual Report. 3) CLC Staffing Methodology Annual Report to the Facility-Based Staffing Methodology will be completed by Expert Panel of the Facility-Based Staffing Methodology Expert Panel in August yearly to analyze the CLC Staffing Methodology Annual Report and make recommendations. This annual report will be reported to the ADPCS/NE and other QUAD members.

# OIG Contact and Staff Acknowledgments

| | |
|---|---|
| **Contact** | For more information about this report, please contact the OIG at (202) 461-4720. |
| **Onsite Contributors** | Elizabeth Burns, MSSW, Team Leader<br>Richard Clark<br>Deborah Howard, RN, MSN<br>Judy Montano, MS<br>Glen Pickens, RN, MHSM<br>Katrina Young, RN, MSHL |
| **Other Contributors** | Elizabeth Bullock<br>Shirley Carlile, BA<br>Paula Chapman, CTRS<br>Lin Clegg, PhD<br>Marnette Dhooghe, MS<br>Matt Frazier, MPH<br>Monika Gottlieb, MD<br>Jerry Herbers, MD<br>Derrick Hudson<br>Jeff Joppie, BS<br>Victor Rhee, MHS<br>Julie Watrous, RN, MS<br>Jarvis Yu, MS |

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U.S. Senate: Mazie K. Hirono, Brian Schatz
U.S. House of Representatives: Tulsi Gabbard, Colleen Hanabusa

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

# Endnotes

[1] References used for this topic included:
- VHA Directive 2009-043, *Quality Management System*, September 11, 2009.
- VHA Handbook 1050.01, *VHA National Patient Safety Improvement Handbook*, March 4, 2011.
- VHA Directive 2010-017, *Prevention of Retained Surgical Items*, April 12, 2010.
- VHA Directive 2010-025, *Peer Review for Quality Management*, June 3, 2010.
- VHA Directive 2010-011, *Standards for Emergency Departments, Urgent Care Clinics, and Facility Observation Beds*, March 4, 2010.
- VHA Directive 2009-064, *Recording Observation Patients*, November 30, 2009.
- VHA Handbook 1100.19, *Credentialing and Privileging*, November 14, 2008.
- VHA Directive 2008-063, *Oversight and Monitoring of Cardiopulmonary Resuscitative Events and Facility Cardiopulmonary Resuscitation Committees*, October 17, 2008.
- VHA Handbook 1907.01, *Health Information Management and Health Records*, September 19, 2012.
- VHA Directive 6300, Records Management, July 10, 2012.
- VHA Directive 2009-005, *Transfusion Utilization Committee and Program*, February 9, 2009.
- VHA Handbook 1106.01, *Pathology and Laboratory Medicine Service Procedures*, October 6, 2008.
- VHA Directive 2008-007, *Resident Assessment Instrument (RAI) Minimum Data Set (MDS)*, February 4, 2008; VHA Handbook 1142.03, *Requirements for Use of the Resident Assessment Instrument (RAI) Minimum Data Set (MDS)*, January 4, 2013.

[2] References used for this topic included:
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