Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 13-00432-217

Combined Assessment Program Review of the Spokane VA Medical Center Spokane, Washington

June 12, 2013

Washington, DC 20420

To Report Suspected Wrongdoing in VA Programs and Operations
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(Hotline Information: www.va.gov/oig/hotline)

Glossary

CACC	Critical and Acute Care Committee
CAP	Combined Assessment Program
CLC	community living center
COC	coordination of care
COS	Chief of Staff
CS	controlled substances
CSC	Construction Safety Committee
EHR	electronic health record
EOC	environment of care
facility	Spokane VA Medical Center
FY	fiscal year
HPC	hospice and palliative care
HRCP	Home Respiratory Care Program
HRCT	home respiratory care team
ICC	Infection Control Committee
IPC	interdisciplinary plan of care
NA	not applicable
NC	noncompliant
NHPPD	nursing hours per patient day
OIG	Office of Inspector General
PCCT	Palliative Care Consult Team
PRC	Peer Review Committee
QM	quality management
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

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Executive Summary

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

Review Results: The review covered eight activities and a follow-up review area from the previous Combined Assessment Program review. We made no recommendations in the following three activities:

- Environment of Care
- Medication Management – Controlled Substances Inspections
- Preventable Pulmonary Embolism

The facility's reported accomplishment was innovation in environment of care rounds, which includes rounding all zoned areas across the organization at least twice annually.

Recommendations: We made recommendations in the following five activities and in the follow-up review area:

Quality Management: Ensure actions from peer reviews are consistently completed and reported to the Peer Review Committee. Require the Critical and Acute Care Committee to review each code episode.

Coordination of Care – Hospice and Palliative Care: Include a dedicated administrative support person and a dedicated psychologist or other mental health provider on the Palliative Care Consult Team, and ensure the team regularly provides end-of-life training. Require that all hospice and palliative care (HPC) staff and non-HPC staff receive end-of-life training. Act upon HPC consults within 7 days of the request. Consistently assess HPC inpatients' pain within 4 hours following an intervention, document the results, and monitor compliance. Consistently implement pain interventions identified on HPC inpatients' care plans. Ensure interdisciplinary plans of care specify responsible team members. Require the community living center social worker to document in the electronic health record that the condolence letter was sent.

Long-Term Home Oxygen Therapy: Ensure the Chief of Staff reviews Home Respiratory Care Program activities at least quarterly. Establish a home respiratory care team, and conduct periodic, unscheduled onsite visits to the oxygen delivery contractor. Ensure that home oxygen program patients have active prescriptions and that patients are re-evaluated for home oxygen therapy annually after the first year. Identify high-risk home oxygen patients. Ensure prescribing clinicians conduct initial and follow-up evaluations of home oxygen program patients.

Nurse Staffing: Include all required members on the facility expert panel. Ensure all members of the facility and unit-based expert panels receive the required training prior to the next annual staffing plan reassessment. Monitor the staffing methodology that was implemented in August 2011.

Construction Safety: Establish a policy outlining responsibilities of the multidisciplinary committee that oversees construction and renovation activities. Include all required elements in documentation of construction site inspections. Conduct infection surveillance activities related to construction projects, and document this in Infection Control Committee minutes. Ensure that Construction Safety Committee minutes contain documentation of follow-up actions in response to unsafe conditions identified during inspections and that minutes track actions to completion. Require designated employees to receive ongoing construction safety training, and monitor compliance. Ensure that when required, continuous negative air pressure is achieved prior to initiating work at a construction site.

Follow-Up on Coordination of Care Issue: Ensure physician orders and discharge summaries are consistent.

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 20–30, 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 and one follow-up review area from the previous CAP review:

- QM
- EOC
- Medication Management – CS Inspections
- COC – HPC
- Long-Term Home Oxygen Therapy
- Nurse Staffing
- Preventable Pulmonary Embolism
- Construction Safety
- Follow-Up on COC Issue

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 28, 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 Spokane VA Medical Center, Spokane, Washington, Report No. 09-01001-130, May 20, 2009). We made a repeat recommendation in COC.

During this review, we presented crime awareness briefings for 148 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 238 responded. We shared summarized results with the facility Director.

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

EOC Rounds Innovation

EOC rounds cover all zoned areas across the organization at least twice annually, and there is a high level of interdisciplinary involvement. A culture of ownership is being developed by involving area managers and staff in conducting service-level EOC rounds more frequently in their respective areas. Additionally, managers and staff are encouraged to initiate work orders for timely issue resolution.

The organization is employing technology to improve efficiency and tracking of EOC tasks. An example is the use of innovative handheld technology (a Wi-Fi tablet) to take pictures, initiate work orders from the point of care, and synchronize in real time with the EOC tracking database.

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 PRC.	Twelve months of PRC meeting minutes reviewed: • Of the 20 actions expected to be completed, 7 were not reported to the PRC.
	Focused Professional Practice Evaluations for newly hired licensed independent practitioners complied with selected requirements.	
	Local policy for the use of observation beds complied with selected requirements.	
	Data regarding appropriateness of observation bed use was gathered, and conversions to acute admissions were less than 30 percent.	
	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.	
X	The cardiopulmonary resuscitation review policy and processes complied with requirements for reviews of episodes of care where resuscitation was attempted.	Twelve months of CACC meeting minutes reviewed: • There was no evidence that the committee reviewed each code episode.
	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.	
	Use and review of blood/transfusions complied with selected requirements.	
	CLC minimum data set forms were transmitted to the data center with the required frequency.	
	Overall, if significant issues were identified, actions were taken and evaluated for effectiveness.	
	There was evidence at the senior leadership level that QM, patient safety, and systems redesign were integrated.	
	Overall, there was evidence that senior managers were involved in performance improvement over the past 12 months.	
	Overall, the facility had a comprehensive, effective QM/performance improvement program over the past 12 months.	
	The facility complied with any additional elements required by VHA or local policy.	

Recommendations

1. We recommended that processes be strengthened to ensure that actions from peer reviews are consistently completed and reported to the PRC.

2. We recommended that processes be strengthened to ensure that the CACC reviews each code episode.

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 audiology, primary care, women's health, and occupational and physical therapy outpatient clinics; the advanced care unit; the CLC; the emergency department; the intensive care unit; and the medical/surgical and mental health inpatient units. Additionally, we reviewed relevant documents and interviewed key employees and managers. The table below shows the areas reviewed for this topic. Items that did not apply to this facility are marked "NA." The facility generally met requirements. We made no recommendations.

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

NC	Areas Reviewed for the Women's Health Clinic (continued)	Findings
	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 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	Findings
	Facility policy was consistent with VHA requirements.	
	VA police conducted annual physical security surveys of the pharmacy/pharmacies, and any identified deficiencies were corrected.	
	Instructions for inspecting automated dispensing machines were documented, included all required elements, and were followed.	
	Monthly CS inspection findings summaries and quarterly trend reports were provided to the facility Director.	
	CS Coordinator position description(s) or functional statement(s) included duties, and CS Coordinator(s) completed required certification and were free from conflicts of interest.	
	CS inspectors were appointed in writing, completed required certification and training, and were free from conflicts of interest.	
	Non-pharmacy areas with CS were inspected in accordance with VHA requirements, and inspections included all required elements.	
	Pharmacy CS inspections were conducted in accordance with VHA requirements and included all required elements.	
	The facility complied with any additional elements required by VHA or local policy.	

COC – 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 22 employee training records (7 HPC staff records and 15 non-HPC staff records), and we interviewed key employees. The table below shows the areas reviewed for this topic. The areas marked as NC needed improvement. Items that did not apply to this facility are marked "NA."

NC	Areas Reviewed	Findings
X	A PCCT was in place and had the dedicated staff required.	List of staff assigned to the PCCT reviewed: • An administrative support person had not been dedicated to the PCCT. • A psychologist or other mental health provider had not been dedicated to the PCCT.
	The PCCT actively sought patients appropriate for HPC.	
X	The PCCT offered end-of-life training.	• We did not find evidence that the PCCT offered end-of-life training.
X	HPC staff and selected non-HPC staff had end-of-life training.	• Of the seven HPC staff, there was no evidence that three had end-of-life training. • Of the 15 non-HPC staff, there was no evidence that 8 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.	
X	The PCCT responded to consults within the required timeframe and tracked consults that had not been acted upon.	• Four consults were not acted upon within 7 days of the request.
	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.	
X	HPC inpatients were assessed for pain with the frequency required by local policy.	• Six EHRs did not contain documentation of pain assessments within 4 hours following an intervention.

NC	Areas Reviewed (continued)	Findings
X	HPC inpatients' pain was managed according to the interventions included in the care plan.	• Four EHRs did not contain documentation that pain was managed according to the interventions included in the IPC.
	HPC inpatients were screened for an advanced directive upon admission and according to local policy.	
X	The facility complied with any additional elements required by VHA or local policy.	• None of the inpatients' IPCs specified responsible team members as required by local policy. • Three of 10 inpatients' EHRs did not contain evidence that the CLC social worker completed the CLC condolence letter as required by local policy.

Recommendations

3. We recommended that processes be strengthened to ensure that the PCCT includes a dedicated administrative support person and a dedicated psychologist or other mental health provider.

4. We recommended that the PCCT provide end-of-life training on a regular basis.

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

6. We recommended that processes be strengthened to ensure that HPC consults are acted upon within 7 days of the request.

7. We recommended that processes be strengthened to ensure that HPC inpatients' pain is consistently assessed within 4 hours following an intervention and results documented in the EHR and that compliance be monitored.

8. We recommended that processes be strengthened to ensure that pain interventions identified on HPC inpatients' IPCs are consistently implemented.

9. We recommended that processes be strengthened to ensure that IPCs specify responsible team members.

10. We recommended that processes be strengthened to ensure that the CLC social worker documents in the EHR that the CLC condolence letter was sent.

Long-Term Home Oxygen Therapy

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

We reviewed relevant documents and 31 EHRs of patients enrolled in the home oxygen program, and we interviewed key employees. The table below shows the areas reviewed for this topic. The areas marked as NC needed improvement. Items that did not apply to this facility are marked "NA."

NC	Areas Reviewed	Findings
	There was a local policy to reduce the fire hazards of smoking associated with oxygen treatment.	
X	The COS reviewed HRCP activities at least quarterly.	• We found no evidence that program activities were reviewed quarterly.
X	The facility had established an HRCT.	• We found no evidence that a team had been established prior to the study period.
X	Contracts for oxygen delivery contained all required elements and were monitored quarterly.	One contract reviewed: • We found no evidence that the Contracting Officer's Technical Representative, or designee, conducted periodic, unscheduled onsite visits to the contractor as required in the contract.
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.	• We found no evidence of active prescriptions for home oxygen in any of the EHRs. • There was no documentation that 19 patients (61 percent) were re-evaluated annually after the first year.
	Patients identified as high risk received hazards education at least every 6 months after initial delivery.	
X	NC high-risk patients were identified and referred to a multidisciplinary clinical committee for review.	• We found no evidence that patients were being identified as high risk.
X	The facility complied with any additional elements required by VHA or local policy.	• We found no evidence that prescribing clinicians conducted follow-up evaluations of home oxygen program patients as required by VHA.

Recommendations

11. We recommended that processes be strengthened to ensure that the COS reviews HRCP activities at least quarterly.

12. We recommended that the facility establish an HRCT.

13. We recommended that the facility conduct periodic, unscheduled onsite visits to the oxygen delivery contractor.

14. We recommended that processes be strengthened to ensure that home oxygen program patients have active prescriptions and that patients are re-evaluated for home oxygen therapy annually after the first year.

15. We recommended that processes be strengthened to ensure that high-risk home oxygen patients are identified.

16. We recommended that processes be strengthened to ensure that prescribing clinicians conduct initial and follow-up evaluations of home oxygen program patients.

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 16 training files, and we interviewed key employees. Additionally, we reviewed the actual NHPPD for acute care unit 3-South and the CLC unit 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. The areas 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.	
X	The facility expert panel followed the required processes and included all required members.	• The facility panel did not include staff nurses or other nursing staff providing direct patient care, Associate or Assistant Nurse Executive(s) with clinical area responsibilities, evening and night supervisory staff, nurse managers from the various areas of the facility, or a labor partner representative.
X	Members of the expert panels completed the required training.	• None of the four members of unit 3-South's panel had completed the required training. • None of the seven members of the CLC unit's panel had completed the required training. • None of the five members of the facility expert panel had completed the required training.
	The facility completed the required steps to develop a nurse staffing methodology by September 30, 2011.	
X	The selected units' actual NHPPD met or exceeded the target NHPPD.	• The facility had not retained the actual NHPPD that was calculated on a daily basis. Therefore, we were unable to determine whether the actual NHPPD met or exceeded the target NHPPD.
	The facility complied with any additional elements required by VHA or local policy.	

Recommendations

17. We recommended that the annual staffing plan reassessment process ensures that all required staff are facility expert panel members.

18. We recommended that all members of the facility and unit-based expert panels receive the required training prior to the next annual staffing plan reassessment.

19. We recommended that nursing managers monitor the staffing methodology that was implemented in August 2011.

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 nine 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. Items that did not apply to this facility are marked "NA." The facility generally met requirements. We made no recommendations.

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

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

Construction Safety

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

We inspected the fire stopping/smoke wall penetration project. Additionally, we reviewed relevant documents and 20 training records (10 contractor records and 10 employee records), and we interviewed key employees and managers. The table below shows the areas reviewed for this topic. The areas marked as NC needed improvement. Items that did not apply to this facility are marked "NA."

NC	Areas Reviewed	Findings
X	There was a multidisciplinary committee to oversee infection control and safety precautions during construction and renovation activities and a policy outlining the responsibilities of the committee, and the committee included all required members.	• The facility did not have a policy outlining responsibilities of the multidisciplinary committee.
	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.	
X	Site inspections were conducted by the required multidisciplinary team members at the specified frequency and included all required elements.	Site inspection documentation for 2 quarters reviewed: • Documentation did not include the time of inspections and time of corrective actions.
X	ICC minutes documented infection surveillance activities associated with the project(s) and any interventions.	ICC minutes for past 2 quarters reviewed: • There was no documentation of infection surveillance activities related to the fire stopping/smoke wall penetration project or any other specific construction project.
X	CSC minutes documented any unsafe conditions found during inspections and any follow-up actions and tracked actions to completion.	CSC minutes for past 2 months reviewed: • Although unsafe conditions were discussed by project in the most recent minutes, the committee had not been operational long enough to track evidence of follow-up actions in the minutes.
X	Contractors and designated employees received required training.	Employee and contractor training records reviewed: • Five employee records did not contain evidence of 10 hours of construction safety-related training in the past 2 years.

NC	Areas Reviewed (continued)	Findings
X	Dust control requirements were met.	• While inspecting the set-up of a new construction site for the project, the CAP team inspector identified problems with continuous negative air pressure. The facility took action to remedy the situation prior to beginning work.
	Fire and life safety requirements were met.	
	Hazardous chemicals requirements were met.	
	Storage and security requirements were met.	
	The facility complied with any additional elements required by VHA or local policy or other regulatory standards.	

Recommendations

20. We recommended that the facility establish a policy outlining responsibilities of the multidisciplinary committee that oversees construction and renovation activities.

21. We recommended that processes be strengthened to ensure that documentation of construction site inspections includes all required elements.

22. We recommended that processes be strengthened to ensure that infection surveillance activities related to construction projects are conducted and documented in ICC minutes.

23. We recommended that processes be strengthened to ensure that CSC minutes contain documentation of follow-up actions in response to unsafe conditions identified during inspections and that minutes track actions to completion.

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

25. We recommended that processes be strengthened to ensure that when required, continuous negative air pressure is achieved prior to initiating work at a construction site.

Review Activity with Previous CAP Recommendations

Follow-Up on COC Issue

As a follow-up to a recommendation from our prior CAP review, we reassessed facility compliance with discharge documentation.

Discharge Documentation. VHA requires a discharge summary that includes information regarding medications, diet, activity level, and follow-up care for all patients released from VHA inpatient care.[9] The facility identified inconsistencies between physician orders and discharge summaries for diet, activity level, and recommendations for follow-up care, and reported that it was not compliant with this requirement.

Recommendation

26. We recommended that processes be strengthened to ensure that physician orders and discharge summaries are consistent.

Facility Profile (Spokane/668) FY 2012[b]	
Type of Organization	Secondary
Complexity Level	3-Low complexity
Affiliated/Non-Affiliated	Affiliated
Total Medical Care Budget in Millions	$158.5
Number of: • **Unique Patients**	29,797
• **Outpatient Visits**	325,416
• **Unique Employees**[c] **(as of last pay period in FY 2012)**	709
Type and Number of Operating Beds: • **Hospital**	36
• **CLC**	34
• **Mental Health**	Not Available
Average Daily Census: (through August 2012) • **Hospital**	24
• **CLC**	26
• **Mental Health**	Not Available
Number of Community Based Outpatient Clinics	2
Location(s)/Station Number(s)	Wenatchee, WA/668GA North Idaho, ID/668GB
VISN Number	20

[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 FY 2012		**Outpatient Scores 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	81.2	73.9	59.0	44.9	50.5	47.2
VISN	65.3	65.3	51.5	49.3	49.9	49.8
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	**	10.1	10.0	**	22.0	15.0
U.S. National	15.5	11.6	12.0	19.7	24.7	18.5

** The number of cases is too small (fewer than 25) to reliably tell how well the facility is performing.

[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: May 3, 2013

From: Network Director, VISN 20 (10N20)

Subject: **Draft Report – CAP Review of the Spokane VA Medical Center, Spokane, WA (668/00)**

To: Director, Seattle Regional Office of Healthcare Inspections (54SE)

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

1. Thank you for the opportunity to provide a status report on follow-up to the findings from the Combined Assessment Program Review of the Spokane VA Medical Center, Spokane, Washington.

2. Attached please find the facility concurrences and responses to each of the findings from the review.

3. If you have additional questions or need further information, please contact Susan Gilbert, Survey Coordinator, VISN 20 at (360) 567-4678.

(original signed by:)
Lawrence H. Carroll

Facility Director Comments

Department of Veterans Affairs **Memorandum**

Date: May 2, 2013

From: Director, Spokane VA Medical Center (668/00)

Subject: **CAP Review of the Spokane VA Medical Center, Spokane, WA**

To: Director, Northwest Network (10N20)

1. Please find attached the Spokane VAMC status report on the follow-up to the findings from the CAP Review at Spokane VA Medical Center, Spokane, WA during the week of February 25, 2013.

2. The Spokane VAMC staff is committed to continuously improving processes and care provided to our Veterans and have worked to correct the recommendations identified in the attached report.

3. If you have additional questions, or need additional information, please contact Betty Braddock at 509-434-7300.

(original signed by:)
Linda K. Reynolds, MA, FACHE
Medical Center Director

Attachment

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 consistently completed and reported to the PRC.

Concur

Target date for completion: July 31, 2013

Facility response: The Risk Manager has developed an action log to follow every action item identified by the Peer Review Committee through to completion. This action log is now a standing agenda item at the Peer Review Committee. Actions will be tracked and monitored monthly.

Recommendation 2. We recommended that processes be strengthened to ensure that the CACC reviews each code episode.

Concur

Target date for completion: July 31, 2013

Facility response: Spokane VAMC developed a process in August 2012 where Quality Management reviews every "Morning Report" document for code blues and rapid responses. These cases are then forwarded to the ICU Nurse Manager to disseminate for review by a provider. When cases are disseminated for review, they are also added to the standing CACC agenda for committee discussion/review. This new process has prevented any review fallouts since its implementation. Quality Management tracks and monitors all codes to ensure all are reviewed in the CACC.

Recommendation 3. We recommended that processes be strengthened to ensure that the PCCT includes a dedicated administrative support person and a dedicated psychologist or other mental health provider.

Concur

Target date for completion: July 31, 2013

Facility response: Spokane VAMC is evaluating staffing to identify an appropriate administrative support person for the PCCT. Administrative Support personnel will be identified and dedicated by June 2013. The CLC Hospice Psychologist will be dedicated to the PCCT by May 2013.

Recommendation 4. We recommended that the PCCT provide end-of-life training on a regular basis.

Concur

Target date for completion: July 31, 2013

Facility response: The PCCT has identified an end-of-life training module, which is now offered through the Talent Management System (TMS). The training module will be assigned to all staff as part of their mandatory annual training. Completion of the module is tracked and monitored through the TMS. Staff and their Supervisors will receive reminders annually when their training is due.

Recommendation 5. We recommended that processes be strengthened to ensure that all HPC staff and non-HPC staff receive end-of-life training.

Concur

Target date for completion: July 31, 2013

Facility response: A 3-hour Hospice/Palliative Care Training has been scheduled April 30 for all PCCT members. This training includes 2 hours of training with 1 hour of questions and answers. Follow-up training will be provided through the Talent Management System (TMS) and will be an annual requirement for all PCCT members.

Annual end-of-life training is currently offered through TMS and has been completed by clinical RN staff. This training will be assigned to all staff for initial and annual training.

Recommendation 6. We recommended that processes be strengthened to ensure that HPC consults are acted upon within 7 days of the request.

Concur

Target date for completion: July 31, 2013

Facility response: While consults are regularly acted upon by the PCCT Nurse Practitioner, in a timely manner, there was a failure to close the consults after contact. The PCCT Nurse Practitioner has received education and is now appropriately closing consults within the seven day timeframe after contacting the Veteran.

The PCCT Nurse Practitioner now receives all consult reminders for follow-up, which previously had been received by the Chief of Social Work.

The Chief of Social Work will monitor consults weekly to ensure that consults are being acted upon and closed in a timely manner.

Recommendation 7. We recommended that processes be strengthened to ensure that HPC inpatients' pain is consistently assessed within 4 hours following an intervention and results documented in the EHR and that compliance be monitored.

Concur

Target date for completion: July 31, 2013

Facility response: The CLC Pain Management Standard Operating Procedure (SOP) has been amended to better illustrate the practice of pain intervention on the Hospice Care Unit. Appropriate CLC staff has been educated about the policy requirement for assessing pain within four hours following an intervention. Training has been documented.

The BCMA Coordinator will continue to monitor for documentation of pain reassessment in the EHR.

Recommendation 8. We recommended that processes be strengthened to ensure that pain interventions identified on HPC inpatients' IPCs are consistently implemented.

Concur

Target date for completion: July 31, 2013

Facility response: The Hospice Case Manager has developed a new process to notify staff when the IPCs are changed or amended. The CLC Nurse Manager has educated all clinical staff of the IPC location. The CLC Nurse Manager has added the Hospice CNA to the care plan meetings to better communicate effective pain interventions for each Veteran. The CLC Nurse Manager will perform random chart audits to ensure that pain interventions identified on HPC inpatients are consistently implemented.

Recommendation 9. We recommended that processes be strengthened to ensure that IPCs specify responsible team members.

Concur

Target date for completion: July 31, 2013

Facility response: The CLC Nurse Manager has educated the Hospice Case Manager regarding the requirement to specify which team members are responsible for certain aspects of care.

The Hospice Case Manager will begin identifying these responsible team members in the Interdisciplinary Plan of Care.

The CLC Nurse Manager will perform random chart audits to ensure that the IPCs specify responsible team members.

Recommendation 10. We recommended that processes be strengthened to ensure that the CLC social worker documents in the EHR that the CLC condolence letter was sent.

Concur

Target date for completion: July 31, 2013

Facility response: The CLC Social Worker has been educated regarding the requirement to document in the EHR that the condolence letters have been sent.

The CLC Social Worker has developed an improved process to ensure the condolence letter is documented in the EHR.

The PCCT Social Worker will review each Hospice case to ensure that condolence letters are documented in the EHR. The PCCT Social Worker will monitor and follow up with the CLC Social Worker with any fallouts.

Recommendation 11. We recommended that processes be strengthened to ensure that the COS reviews HRCP activities at least quarterly.

Concur

Target date for completion: July 31, 2013

Facility response: The Home Oxygen Report has been added to the Clinical Executive Council (CEC) as a standing agenda item for quarterly review.

Review will begin with the CEC meeting in May and documented in the meeting minutes.

Recommendation 12. We recommended that the facility establish an HRCT.

Concur

Target date for completion: July 31, 2013

Facility response: The Home Respiratory Care Team (HRCT) was established in December 2012. The HRCT began meeting monthly in December 2012. Monitoring of the Home Oxygen Program is documented in the HRCT meeting minutes.

The HRCT will report quarterly to the Clinical Executive Committee (CEC).

Recommendation 13. We recommended that the facility conduct periodic, unscheduled onsite visits to the oxygen delivery contractor.

Concur

Target date for completion: July 31, 2013

Facility response: Periodic unscheduled onsite visits to the contractor are occurring and will continue quarterly and will be documented per the Directive. Quality Management will track and monitor that quarterly onsite visits are completed and any/all actions are documented.

Recommendation 14. We recommended that processes be strengthened to ensure that home oxygen program patients have active prescriptions and that patients are re-evaluated for home oxygen therapy annually after the first year.

Concur

Target date for completion: July 31, 2013

Facility response: A new process has been developed so that prescriptions, when initiated or renewed, are signed by the prescribing physician and documented in the EHR. The Home Oxygen Coordinator will submit consults, which will be held until an order has been signed. The Home Oxygen Coordinator will follow up with the prescribing physician after the initial and annual evaluations to ensure the orders are entered timely.

The Home Oxygen Coordinator has developed an improved process to ensure annual evaluations are completed timely. The Home Oxygen Coordinator now runs reports for upcoming annual reassessments 30-60 days prior to the actual due date. This allows for timely scheduling of the Veteran prior to prescription expiration. Once the Home Oxygen Coordinator completes the annual reassessment, an appointment will be entered into the prescribing physician's schedule for annual reassessment. This process will be monitored by the Home Respiratory Care Team (HRCT).

Recommendation 15. We recommended that processes be strengthened to ensure that high-risk home oxygen patients are identified.

Concur

Target date for completion: July 31, 2013

Facility response: The Home Respiratory Care Coordinator has developed a spread sheet to track all high-risk patients and when their six (6) month refresher education is due. This spreadsheet will be completely populated with current Veterans by July 2013.

The Home Respiratory Care Coordinator will review all current home oxygen patients to ensure high-risk patients are identified in the electronic health record. Going forward all patients identified as high-risk during initial evaluation will be identified as such in the electronic health record and on the high-risk spread sheet. This process will be monitored by the Home Respiratory Care Team (HRCT).

Recommendation 16. We recommended that processes be strengthened to ensure that prescribing clinicians conduct initial and follow-up evaluations of home oxygen program patients.

Concur

Target date for completion: July 31, 2013

Facility response: A process has been developed giving the Home Oxygen Coordinator access to the prescribing physician's schedule. The Home Oxygen Coordinator will schedule the prescribing physician to conduct initial and follow-up evaluations with the Veteran.

The Home Oxygen Coordinator will track and monitor scheduled evaluations to completion. Weekly, the Home Oxygen Coordinator will follow-up with any prescribing physicians that have not completed initial or follow-up evaluations. This process will be monitored by the Home Respiratory Care Team (HRCT).

Recommendation 17. We recommended that the annual staffing plan reassessment process ensures that all required staff are facility expert panel members.

Concur

Target date for completion: July 31, 2013

Facility response: The Spokane VAMC Associate Director of Patient Care Services (ADPCS) has identified and appointed all of the required staff to the facility expert panel as required by the staffing methodology for nursing personnel.

The appointed staff will complete the required chapters as required by the staffing methodology for nursing personnel. This education will be tracked and documented by Nursing Service.

Recommendation 18. We recommended that all members of the facility and unit-based expert panels receive the required training prior to the next annual staffing plan reassessment.

Concur

Target date for completion: July 31, 2013

Facility response: The annual staffing plan reassessment is due August 2013. Prior to the staffing plan reassessment, the ADPCS will ensure that members of the facility-based panel and unit-based panels complete all required training.

All required training will be documented in the TMS.

Recommendation 19. We recommended that nursing managers monitor the staffing methodology that was implemented in August 2011.

Concur

Target date for completion: July 31, 2013

Facility response: A database has been consolidated to include minimum, maximum, and actual HPPD data.

This data base will be updated each shift.

The HPPD data base will be monitored by Nurse Managers, Deputy Chief of Nursing, and the Nurse Executive monthly.

Recommendation 20. We recommended that the facility establish a policy outlining responsibilities of the multidisciplinary committee that oversees construction and renovation activities.

Concur

Target date for completion: July 31, 2013

Facility response: A policy outlining responsibilities of the multidisciplinary Construction Safety Committee has been developed and signed by the Medical Center Director. Activities of the committee will be documented in their meeting minutes. The committee reports quarterly to Environment of Care Committee.

Recommendation 21. We recommended that processes be strengthened to ensure that documentation of construction site inspections includes all required elements.

Concur

Target date for completion: July 31, 2013

Facility response: The construction site inspections form has been amended to include all members present, along with the date and time of the inspection. The construction forms will be standing agenda items at the Construction Safety Committee where findings will be discussed and tracked to completion. Discussion and tracking will be documented in the meeting minutes.

Recommendation 22. We recommended that processes be strengthened to ensure that infection surveillance activities related to construction projects are conducted and documented in ICC minutes.

Concur

Target date for completion: July 31, 2013

Facility response: Infection Control inspections have been added to the Infection Control spreadsheet, which is a standing agenda item on the Infection Control Committee agenda. Infection Control is part of the Construction Safety Committee and will conduct infection surveillance activities regularly on all construction projects.

Documentation of any issues and/or corrective actions will be included in the meeting minutes of the Construction Safety Committee and the Infection Control Committee and tracked to completion.

Recommendation 23. We recommended that processes be strengthened to ensure that CSC minutes contain documentation of follow-up actions in response to unsafe conditions identified during inspections and that minutes track actions to completion.

Concur

Target date for completion: July 31, 2013

Facility response: The Construction Safety Committee has a process in place to document follow-up actions for unsafe conditions identified during inspections.

The Construction Safety Committee has a standing agenda item used to discuss unsafe conditions. These items will be tracked to correction/completion. The Construction Safety Committee reports quarterly to the Environment of Care Committee.

Recommendation 24. We recommended that processes be strengthened to ensure that designated employees receive ongoing construction safety training and that compliance be monitored.

Concur

Target date for completion: July 31, 2013

Facility response: Construction safety training had been completed by all members of the Construction Safety Committee by January 2013.

The Construction Safety Committee will provide ongoing construction training quarterly.

Training will be documented in the Construction Safety Committee minutes.

Recommendation 25. We recommended that processes be strengthened to ensure that when required, continuous negative air pressure is achieved prior to initiating work at a construction site.

Concur

Target date for completion: July 31, 2013

Facility response: Education with contract personnel was completed immediately to ensure proper set-up of continuous negative air pressure prior to initiating work.

Additionally, inspections are routinely conducted prior to initiation of work, during work and prior to removal of barriers at all sites requiring negative air flow. Inspection activity will be documented in the Construction Safety Committee minutes and the Infection Control Committee minutes.

Recommendation 26. We recommended that processes be strengthened to ensure that physician orders and discharge summaries are consistent.

Concur

Target date for completion: August 2013

Facility response: Spokane VAMC will develop a dictation template that will prompt the provider to dictate discharge summaries based on their discharge orders.

The Chief of Staff and Chief of Surgery will educate discharging providers during Interdisciplinary Team huddles and one-on-one on the requirement to ensure discharge summaries match discharge orders through use of the discharge template. This training will be documented with signed acknowledgement by each provider.

Spokane VAMC will do monthly random chart audits to ensure discharge summaries are matching discharge orders. When a provider is found non-compliant, the Chief of Medicine and Chief of Staff will be notified, so that one-on-one counseling can occur.

Appendix E

OIG Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the OIG at (202) 461-4720.
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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.
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- VHA Handbook 1330.01, *Health Care Services for Women Veterans*, May 21, 2010.
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- Various requirements of The Joint Commission, the Centers for Disease Control and Prevention, the Occupational Safety and Health Administration, the National Fire Protection Association, the American National Standards Institute, the Association for the Advancement of Medical Instrumentation, and the International Association of Healthcare Central Service Material Management.

[3] References used for this topic included:
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- VHA Handbook 1108.02, *Inspection of Controlled Substances*, March 31, 2010.
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- VHA Handbook 1108.06, *Inpatient Pharmacy Services*, June 27, 2006.
- VHA, "Clarification of Procedures for Reporting Controlled Substance Medication Loss as Found in VHA Handbook 1108.01," Information Letter 10-2011-004, April 12, 2011.
- VA Handbook 0730, *Security and Law Enforcement*, August 11, 2000.
- VA Handbook 0730/2, *Security and Law Enforcement*, May 27, 2010.

[4] References used for this topic included:
- VHA Directive 2008-066, *Palliative Care Consult Teams (PCCT)*, October 23, 2008.
- VHA Directive 2008-056, *VHA Consult Policy*, September 16, 2008.
- VHA Handbook 1004.02, *Advanced Care Planning and Management of Advance Directives*, July 2, 2009.
- VHA Handbook 1142.01, *Criteria and Standards for VA Community Living Centers (CLC)*, August 13, 2008.
- VHA Directive 2009-053, *Pain Management*, October 28, 2009.
- Under Secretary for Health, "Hospice and Palliative Care are Part of the VA Benefits Package for Enrolled Veterans in State Veterans Homes," Information Letter 10-2012-001, January 13, 2012.

[5] References used for this topic were:
- VHA Directive 2006-021, *Reducing the Fire Hazard of Smoking When Oxygen Treatment is Expected*, May 1, 2006.
- VHA Handbook 1173.13, *Home Respiratory Care Program*, November 1, 2000.

[6] The references used for this topic were:
- VHA Directive 2010-034, *Staffing Methodology for VHA Nursing Personnel*, July 19, 2010.
- VHA "Staffing Methodology for Nursing Personnel," August 30, 2011.

[7] The reference used for this topic was:
- VHA Office of Analytics and Business Intelligence, *External Peer Review Technical Manual*, FY2012 quarter 4, June 15, 2012, p. 80–98.

[8] References used for this topic included:
- VHA Directive 2011-036, *Safety and Health During Construction*, September 22, 2011.
- VA Office of Construction and Facilities Management, *Master Construction Specifications*, Div. 1, "Special Sections," Div. 01 00 00, "General Requirements," Sec. 1.5, "Fire Safety."
- Various Centers for Disease Control and Prevention recommendations and guidelines, Joint Commission standards, and Occupational Safety and Health Administration (OSHA) regulations.

[9] The reference used for this topic was:
VHA Handbook 1907.01, *Health Information Management and Health Records*, September 19, 2012.