Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 13-00896-234

Combined Assessment Program Review of the VA Maryland Health Care System Baltimore, Maryland

July 11, 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
CPR	cardiopulmonary resuscitation
CS	controlled substances
EHR	electronic health record
EOC	environment of care
facility	VA Maryland Health Care System
FPPE	Focused Professional Practice Evaluation
FY	fiscal year
HPC	hospice and palliative care
IC	infection control
ICU	intensive care unit
MH	mental health
NA	not applicable
NC	noncompliant
OIG	Office of Inspector General
PCCT	Palliative Care Consult Team
PU	pressure ulcer
QM	quality management
RME	reusable medical equipment
SPS	Sterile Processing Service
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 April 22, 2013.

Review Results: The review covered seven activities. The facility's reported accomplishment was the Final Salute for deceased veterans.

Recommendations: We made recommendations in all seven of the following activities:

Quality Management: Consistently report Focused Professional Practice Evaluation results for newly hired licensed independent practitioners to the Medical Executive Committee. Revise the local observation bed policy to include all required elements, and gather data about observation bed use. Review each non-intensive care unit cardiopulmonary resuscitation code episode, and ensure code reviews include screening for clinical issues that may have contributed to code occurrences. Include all services in the review of electronic health record quality. Ensure that the quality control policy for scanning includes linking the scanned documents to the correct record and that the results of non-VA purchased diagnostic tests are consistently scanned into electronic health records. Include the results of proficiency testing in the blood usage and review process.

Environment of Care: Ensure Environment of Care Committee minutes reflect that actions taken in response to identified deficiencies are tracked to closure. Properly secure oxygen tanks, and store them in a manner that distinguishes between empty and full tanks. Secure soiled utility rooms at all times. Consistently conduct environment of care rounds in the Annex building.

Medication Management – Controlled Substances Inspections: Amend facility policy to include that Controlled Substances (CS) Coordinators have complete understanding of CS policies and the inspection process and to include CS inspector orientation and training requirements. Amend instructions for inspecting automated dispensing machines to include monthly CS inspector reconciliation of 1 day's dispensing activity. Ensure monthly CS inspection finding summaries and quarterly trend reports provided to the facility Director include a complete list of the required inspections that were not conducted. Inspect all required non-pharmacy areas with CS.

Coordination of Care – Hospice and Palliative Care: Ensure non-hospice and palliative care clinical staff who provide care to patients at the end of their lives receive end-of-life training.

Pressure Ulcer Prevention and Management: Revise facility pressure ulcer (PU) policy to address prevention for outpatients. Consistently provide and document completion of

recommended PU interventions and education for patients at risk for and with PUs and/or their caregivers. Establish staff PU education requirements. Ensure electrical medical equipment in PU patient rooms receives an electrical safety inspection.

Nurse Staffing: Comply with all elements of the staffing methodology implemented in December 2012.

Construction Safety: Include all required members on the multidisciplinary committee responsible for construction and renovation oversight. Conduct tuberculosis risk assessments prior to construction project initiation. Ensure designated employees receive ongoing construction safety training.

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, conversed with 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
- PU Prevention and Management
- Nurse Staffing
- Construction Safety

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

The review covered facility operations for FY 2012 and FY 2013 through April 26, 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 Maryland Health Care System, Baltimore, Maryland,* Report No. 09-01730-14, October 21, 2009).

During this review, we presented crime awareness briefings for 170 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 294 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

The Final Salute

The Final Salute is a means to show respect and gratitude for the service of deceased veterans and to provide closure for their families and staff. When a veteran passes away, all activity ceases on the unit, and staff and veterans line the corridors as the deceased veteran is taken to the hearse. Following the Loch Raven campus' 2010 initiative, the Final Salute now extends to all facility campuses.

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 areas marked as NC needed improvement. Any 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.	Nine profiles reviewed: • Of the eight FPPEs completed, results of two were not reported to the Medical Executive Committee.
X	Local policy for the use of observation beds complied with selected requirements.	• The facility's policy did not include that each observation patient must have a focused goal for the period of observation and that each admission must have a limited severity of illness and a condition appropriate for observation.
X	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.	• The facility did not gather observation bed use data.
	Staff performed continuing stay reviews on at least 75 percent of patients in acute beds.	
	Appropriate processes were in place to prevent incidents of surgical items being retained in a patient following surgery.	

NC	Areas Reviewed (continued)	Findings
X	The CPR review policy and processes complied with requirements for reviews of episodes of care where resuscitation was attempted.	Six months of CPR Committee meeting minutes reviewed. There was no evidence that: • The committee reviewed each code episode. • Code reviews included screening for clinical issues prior to non-ICU codes that may have contributed to the occurrence of the code.
X	There was an EHR quality review committee, and the review process complied with selected requirements.	Six months of EHR Committee meeting minutes reviewed: • Not all services were included in review of EHR quality.
	The EHR copy and paste function was monitored.	
X	Appropriate quality control processes were in place for non-VA care documents, and the documents were scanned into EHRs.	• The quality control policy for scanning did not include linking the scanned documents to the correct record. Twenty-six EHRs of patients who had non-VA purchased diagnostic tests reviewed: • Four test results were not scanned into the EHRs.
X	Use and review of blood/transfusions complied with selected requirements.	Three quarters of Transfusion Utilization Committee meeting minutes reviewed: • The review process did not include the results of proficiency testing.
	CLC minimum data set forms were transmitted to the data center with the required frequency.	
	Overall, if significant issues were identified, actions were taken and evaluated for effectiveness.	
	There was evidence at the senior leadership level that QM, patient safety, and systems redesign were integrated.	
	Overall, there was evidence that senior managers were involved in performance improvement over the past 12 months.	
	Overall, the facility had a comprehensive, effective QM/performance improvement program over the past 12 months.	
	The facility complied with any additional elements required by VHA or local policy.	

Recommendations

1. We recommended that processes be strengthened to ensure that FPPE results for newly hired licensed independent practitioners are consistently reported to the Medical Executive Committee.

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

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

4. We recommended that processes be strengthened to ensure that the CPR Committee reviews each code episode and that code reviews include screening for clinical issues prior to non-ICU codes that may have contributed to the occurrence of the events.

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

6. We recommended that the quality control policy for scanning includes linking the scanned documents to the correct record.

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

8. We recommended that processes be strengthened to ensure that the blood usage and review process includes the results of proficiency testing.

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 and whether selected requirements in the hemodialysis and SPS areas were met.[2]

At the Baltimore campus, we inspected the emergency department, the medical ICU, the surgical ICU, medical-surgical unit 5B, the dental clinic, the women's health clinic, SPS, and the Annex building. At the Loch Raven campus, we inspected the CLC/rehabilitation, CLC hospice/long-term care, and physical medicine and rehabilitation units. At the Perry Point campus, we inspected the locked MH unit, the CLC units, SPS, and the urgent care center. Additionally, we reviewed relevant documents, conversed with key employees and managers, and reviewed 20 employee training and competency files (10 operating room and 10 SPS). The table below shows the areas reviewed for this topic. The areas marked as NC needed improvement. Any items that did not apply to this facility are marked NA.

NC	Areas Reviewed for General EOC	Findings
X	EOC Committee minutes reflected sufficient detail regarding identified deficiencies, corrective actions taken, and tracking of corrective actions to closure.	Six months of EOC Committee meeting minutes reviewed: • Minutes did not reflect that actions were tracked to closure.
	An infection prevention risk assessment was conducted, and actions were implemented to address high-risk areas.	
	Infection Prevention/Control Committee minutes documented discussion of identified problem areas and follow-up on implemented actions and included analysis of surveillance activities and data.	
	Fire safety requirements were met.	
X	Environmental safety requirements were met.	Of the 16 patient care areas inspected: • Seven did not have oxygen tanks stored in a manner that distinguished between empty and full tanks. Additionally, in four of those seven areas, tanks were not properly secured in holders. • Five had unsecured soiled utility rooms.
	Infection prevention requirements were met.	
	Medication safety and security requirements were met.	
	Sensitive patient information was protected, and patient privacy requirements were met.	
X	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.	VHA and local policy reviewed: • EOC rounds were not conducted in the Annex building.

	Areas Reviewed for Hemodialysis	
NA	The facility had policy detailing the cleaning and disinfection of hemodialysis equipment and environmental surfaces and the management of infection prevention precautions patients.	
NA	Monthly biological water and dialysate testing were conducted and included required components, and identified problems were corrected.	
NA	Employees received training on blood borne pathogens.	
NA	Employee hand hygiene monitoring was conducted, and any needed corrective actions were implemented.	
NA	Selected EOC/infection prevention/safety requirements were met.	
NA	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.	
	Areas Reviewed for SPS/RME	
	The facility had policies/procedures/guidelines for cleaning, disinfecting, and sterilizing RME.	
	The facility used an interdisciplinary approach to monitor compliance with established RME processes, and RME-related activities were reported to an executive-level committee.	
	The facility had policies/procedures/guidelines for immediate use (flash) sterilization and monitored it.	
	Employees received required RME training and competency assessment.	
	Operating room employees who performed immediate use (flash) sterilization received training and competency assessment.	
	RME standard operating procedures were consistent with manufacturers' instructions, procedures were located where reprocessing occurs, and sterilization was performed as required.	
	Selected infection prevention/environmental safety requirements were met.	
	Selected requirements for SPS decontamination and sterile storage areas were met.	
	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.	

Recommendations

9. We recommended that processes be strengthened to ensure that EOC Committee minutes reflect that actions taken in response to identified deficiencies are tracked to closure.

10. We recommended that processes be strengthened to ensure that oxygen tanks are properly secured and stored in a manner that distinguishes between empty and full tanks.

11. We recommended that processes be strengthened to ensure that soiled utility rooms are secured at all times.

12. We recommended that processes be strengthened to ensure that EOC rounds are consistently conducted in the Annex building in accordance with VHA and local policy.

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 10 CS areas, the inpatient and outpatient pharmacies, and the emergency drug cache. The table below shows the areas reviewed for this topic. The areas marked as NC needed improvement. Any items that did not apply to this facility are marked NA.

NC	Areas Reviewed	Findings
X	Facility policy was consistent with VHA requirements.	Facility CS inspection policy reviewed. The policy did not include: • That the CS Coordinators must have complete understanding of CS policies and the VHA inspection process. • Requirements for new CS inspector orientation and/or annual training thereafter.
	VA police conducted annual physical security surveys of the pharmacy/pharmacies, and any identified deficiencies were corrected.	
X	Instructions for inspecting automated dispensing machines were documented, included all required elements, and were followed.	Automated dispensing machine inspection instructions reviewed: • Instructions did not include monthly CS inspector reconciliation of 1 day's dispensing activity, and CS inspectors did not reconcile 1 day's dispensing from the pharmacy to each automated unit.
X	Monthly CS inspection findings summaries and quarterly trend reports were provided to the facility Director.	• Two monthly CS inspection findings summaries and the two corresponding quarterly trend reports did not include a complete list of the required inspections that were not conducted.
	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 10 CS areas inspected during the past 6 months reviewed: • Thirteen of 60 (22 percent) inspections of required areas were not conducted. Additionally, 2 areas were not inspected for 2 consecutive months.

NC	Areas Reviewed (continued)	Findings
	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.	

Recommendations

13. We recommended that facility policy be amended to include that CS Coordinators must have complete understanding of CS policies and the VHA inspection process and to include requirements for new CS inspector orientation and/or annual training thereafter.

14. We recommended that the instructions for inspecting automated dispensing machines be amended to include monthly CS inspector reconciliation of 1 day's dispensing activity and that compliance be monitored.

15. We recommended that processes be strengthened to ensure that monthly CS inspection findings summaries and quarterly trend reports provided to the facility Director include a complete list of the required inspections that were not conducted.

16. We recommended that processes be strengthened to ensure that all required non-pharmacy areas with CS are inspected 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. The area marked as NC needed improvement. Any 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.	• There was no evidence that five 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.	

Recommendation

17. We recommended that processes be strengthened to ensure that non-HPC clinical staff who provide care to patients at the end of their lives receive end-of-life training.

PU Prevention and Management

The purpose of this review was to determine whether acute care clinicians provided comprehensive PU prevention and management.[5]

We reviewed relevant documents, 23 EHRs of patients with PUs (10 patients with hospital-acquired PUs, 10 patients with community-acquired PUs, and 3 patients with PUs at the time of our onsite visit), and 10 employee training records. Additionally, we inspected three patient rooms. The table below shows the areas reviewed for this topic. The areas marked as NC needed improvement. Any items that did not apply to this facility are marked NA.

NC	Areas Reviewed	Findings
X	The facility had a PU prevention policy, and it addressed prevention for all inpatient areas and for outpatient care.	Facility PU prevention policy reviewed: • The policy did not address prevention for outpatients.
	The facility had an inter-professional PU committee, and the membership included a certified wound care specialist.	
	PU data was analyzed and reported to facility executive leadership.	
	Complete skin assessments were performed within 24 hours of acute care admissions.	
	Skin inspections and risk scales were performed upon transfer, change in condition, and discharge.	
	Staff were generally consistent in documenting location, stage, risk scale score, and date acquired.	
	Required activities were performed for patients determined to be at risk for PUs and for patients with PUs.	
	Required activities were performed for patients determined to not be at risk for PUs.	
X	For patients at risk for and with PUs, interprofessional treatment plans were developed, interventions were recommended, and EHR documentation reflected that interventions were provided.	• Nine of the 20 applicable EHRs did not contain consistent documentation that recommended PU interventions were provided.
	If the patient's PU was not healed at discharge, a wound care follow-up plan was documented, and the patient was provided appropriate dressing supplies.	
X	The facility defined requirements for patient and caregiver PU education, and education on PU prevention and development was provided to those at risk for and with PUs and/or their caregivers.	Facility PU patient and caregiver education requirements reviewed: • For nine of the 20 applicable patients, EHRs did not contain evidence that education was provided to patients and/or their caregivers.

NC	Areas Reviewed (continued)	Findings
X	The facility defined requirements for staff PU education, and acute care staff received training on how to administer the PU risk scale, conduct the complete skin assessment, and accurately document findings.	• The facility had not developed staff PU education requirements.
X	The facility complied with selected fire and environmental safety, infection prevention, and medication safety and security requirements in PU patient rooms.	Three PU patient rooms inspected: • In all three rooms, electrical medical equipment, including two alternating pressure mattresses and a compression pump, did not have evidence of required safety inspections.
	The facility complied with any additional elements required by VHA or local policy.	

Recommendations

18. We recommended that the facility PU policy be revised to address prevention for outpatients and that compliance with the revised policy be monitored.

19. We recommended that processes be strengthened to ensure that acute care staff consistently provide and document completion of recommended PU interventions and that compliance be monitored.

20. We recommended that processes be strengthened to ensure that acute care staff provide and document PU education for patients at risk for and with PUs and/or their caregivers and that compliance be monitored.

21. We recommended that the facility establish staff PU education requirements and that compliance be monitored.

22. We recommended that processes be strengthened to ensure that electrical medical equipment in PU patient rooms receives an electrical safety inspection and that compliance be monitored.

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 three inpatient units (acute medical/surgical, long-term care, and MH).[6]

We reviewed relevant documents and 25 training files, and we conversed with key employees. Additionally, we reviewed the actual nursing hours per patient day for acute medical/surgical unit 5B, CLC unit 2 (Loch Raven), and MH unit 6A for 52 randomly selected days (holidays, weekdays, and weekend days) between October 1, 2012, and March 31, 2013. The table below shows the areas reviewed for this topic. The area marked as NC needed improvement. Any items that did not apply to this facility are marked NA.

NC	Areas Reviewed	Findings
X	The facility completed the required steps to develop a nurse staffing methodology by the deadline.	• Expert panels were not convened until December 21, 2012.
NA	The unit-based expert panels followed the required processes and included all required members.	
NA	The facility expert panel followed the required processes and included all required members.	
NA	Members of the expert panels completed the required training.	
NA	The actual nursing hours per patient day met or exceeded the target nursing hours per patient day.	
NA	The facility complied with any additional elements required by VHA or local policy.	

Recommendation

23. We recommended that nursing managers ensure compliance with all elements of the staffing methodology that was implemented in December 2012.

Construction Safety

The purpose of this review was to determine whether the facility maintained IC and safety precautions during construction and renovation activities in accordance with applicable standards.[7]

We relevant reviewed documents for the SPS closet temperature and humidity control construction project at the Baltimore Campus. We were unable to inspect the construction site due to the project's completion 2 days prior to our visit. Additionally, we reviewed 20 training records (10 contractor records and 10 employee records), and we conversed with key employees and managers. The table below shows the areas reviewed for this topic. The areas marked as NC needed improvement. Any items that did not apply to this facility are marked NA.

NC	Areas Reviewed	Findings
X	There was a multidisciplinary committee to oversee IC 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's multidisciplinary committee did not include all required members.
X	IC, preconstruction, interim life safety, and contractor tuberculosis risk assessments were conducted prior to project initiation.	Risk assessments reviewed: • The tuberculosis risk assessment was not conducted prior to the project's initiation.
	There was documentation of results of contractor tuberculosis skin testing and of follow-up on any positive results.	
	There was a policy addressing Interim Life Safety Measures, and required Interim Life Safety Measures were documented.	
	Site inspections were conducted by the required multidisciplinary team members at the specified frequency and included all required elements.	
	IC Committee minutes documented infection surveillance activities associated with the project(s) and any interventions.	
	Construction Safety Committee minutes documented any unsafe conditions found during inspections and any follow-up actions and tracked actions to completion.	
X	Contractors and designated employees received required training.	Employee and contractor training records reviewed: • Five employee records did not contain evidence of at least 10 hours of construction safety-related training in the past 2 years.
NA	Dust control requirements were met.	
NA	Fire and life safety requirements were met.	
NA	Hazardous chemicals requirements were met.	

NC	Areas Reviewed (continued)	Findings
NA	Storage and security requirements were met.	
	The facility complied with any additional elements required by VHA or local policy or other regulatory standards.	

Recommendations

24. We recommended that the facility ensure that the multidisciplinary committee responsible for construction and renovation oversight includes all required members.

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

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

Facility Profile (Baltimore/512) FY 2013 through March 2013[a]	
Type of Organization	Tertiary
Complexity Level	1b
Affiliated/Non-Affiliated	Affiliated
Total Medical Care Budget in Millions (FY 2012)	$530.2
Number of:	
• **Unique Patients**	42,815
• **Outpatient Visits**	315,237
• **Unique Employees**[b]	2,563
Type and Number of Operating Beds: (through February 2013)	
• **Hospital**	236
• **CLC**	263
• **MH**	193
Average Daily Census: (through February 2013)	
• **Hospital**	136
• **CLC**	250
• **MH**	112
Number of Community Based Outpatient Clinics	6
Location(s)/Station Number(s)	Cambridge/512GA Glen Burnie/512GC Loch Raven/512GD Pocomoke City/512GE Fort Howard/512GF Fort Meade/512GG
VISN Number	5

[a] All data is for FY 2013 through March 2013 except where noted.
[b] Unique employees involved in direct medical care (cost center 8200) from most recent pay period.

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	50.8	51.4	50.8	59.0	51.0	51.1
VISN	52.9	56.1	53.4	57.1	50.8	50.9
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.[c] 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.[d]

Table 2

	Mortality			Readmission		
	Heart Attack	Heart Failure	Pneumonia	Heart Attack	Heart Failure	Pneumonia
Facility	14.8	9.9	12.6	22.4	28.3	23.9
U.S. National	15.5	11.6	12.0	19.7	24.7	18.5

[c] 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.

[d] 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: June 14, 2013

From: Director, VA Capitol Health Care Network (10N5)

Subject: **CAP Review of the VA Maryland Health Care System, Baltimore, MD**

To: Director, Baltimore Office of Healthcare Inspections (54BA)

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

1. I have reviewed the comments provided by the Medical Center Director, VA Maryland Health Care System and concur with the responses and actions to the recommendations outlined in the report.

2. Should you require any additional information, please contact Jeffrey Lee, Quality Management Officer, VA Capitol Health Care Network, VISN 5 at 410-691-7816.

Fernando O. Rivera, FACHE

Facility Director Comments

Department of Veterans Affairs **Memorandum**

Date: June 11, 2013

From: Director, VA Maryland Health Care System (512/00)

Subject: **CAP Review of the VA Maryland Health Care System, Baltimore, MD**

To: Director, VA Capitol Health Care Network (10N5)

1. I appreciate the opportunity to review and provide comments to the draft report of the Combined Assessment Program (CAP) review of the VA Maryland Health Care System (VAMHCS), Baltimore, Maryland, during the week of April 22–25, 2013. The findings and recommendations have been review with the senior leadership at the VAMHCS.

2. I concur with the recommendations in the report. The VAMHCS has already begun to implement improvement actions.

3. If you have any questions, please contact my office at (410) 605-7016.

Dennis H. Smith

Comments to OIG's Report

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

OIG Recommendations

Recommendation 1. We recommended that processes be strengthened to ensure that FPPE results for newly hired licensed independent practitioners are consistently reported to the Medical Executive Committee.

Concur

Target date for completion: Completed May 2, 2013

Facility response: The identified providers were scheduled prior to the OIG CAP visit to be presented at the May 2, 2013, Executive Committee of the Medical Staff/Professional Standards Board (ECMS/PSB) as part of a review and implementation of a FPPE tracking system. This system assures that all completed and final FPPEs are tracked and reported to the ECMS/PSB. FPPEs are now tracked in the Priv+ data base. A report was and can now be run to determine all providers who have not completed the FPPE.

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

Concur

Target date for completion: September 30, 2013

Facility response: The facility has identified that the current policies/SOPs need to be reviewed and that a policy be developed with input from the primary medical provider stakeholders. The draft policy will then be sent for concurrence and comment to all involved parties. If any corrections are needed, they will be performed and the policy will be published and implemented.

Recommendation 3. We recommended that processes be strengthened to ensure that data about observation bed use is gathered.

Concur

Target date for completion: October 2013, dependent on National Utilization Management Initiative (NUMI) upgrade release

Facility response: The new Observation Directive is scheduled to be available the beginning of October 2013. Observation reviews in NUMI 1.1.14 will be released around the first week of June 2013. All data will be pulled from NUMI monthly and

reported to the Clinical Center PI Sub Councils on a quarterly basis. If the release of NUMI upgrade is not scheduled by the national office by mid-September, an interim database will be created and utilized for capturing and analyzing how observation beds are used.

Recommendation 4. We recommended that processes be strengthened to ensure that the CPR Committee reviews each code episode and that code reviews include screening for clinical issues prior to non-ICU codes that may have contributed to the occurrence of the events.

Concur

Target date for completion: August 2013

Facility response: Two electronic code notes (Code Blue/Rapid Response Note – Providers and Code Blue/Rapid Response Note-Nursing) have been developed and are undergoing revisions. Notes are currently being tested to gather feedback from the end users. Development of an electronic Code Critique Form has begun. Education began targeting the Critical Care and Emergency Department Nurses who respond to all codes. The electronic documentation is expected to improve documentation compliance and increase capture of all code events for analysis. Charts and critiques will be reviewed and screened for clinical issues that may have contributed to the non ICU codes. Results will be reviewed during the CPR Subcommittee Meetings scheduled to meet monthly.

Recommendation 5. We recommended that processes be strengthened to ensure that the review of EHR quality includes all services.

Concur

Target date for completion: July 2013

Facility response: The calendar (schedule) is updated annually, and provided to the clinical services. The Business Managers or representative for the Clinical Services will continue to be reminded by the Health Information Management (HIM) Specialist prior to the Medical Record Committee (MRC) of their need to report. The Chairperson of MRC will also inform the Clinical Service Chief of the delay in timely reporting of Medical Record Reviews by their respective service. It is the responsibility of the Clinical Service to designate someone to report on Medical Record Reviews, in the absence of the designated person. In the instance of two missed reports by a service, the Chief of Staff will be notified.

Recommendation 6. We recommended that the quality control policy for scanning includes linking the scanned documents to the correct record.

Concur

Target date for completion: June 14, 2013

Facility response: The current Scanning SOP will be revised. The language will be updated to include sampling of non-VA documents including Fee documents, to ensure they are linked to the correct note title for each document. This process will be audited by the supervisor on a periodic basis.

Recommendation 7. We recommended that processes be strengthened to ensure that the results of non-VA purchased diagnostic tests are consistently scanned into EHRs.

Concur

Target date for completion: June 2013

Facility response: The results of Non-VA purchased diagnostic tests are required to be scanned into CPRS by HIMs within 3 business days of notification of availability by our Fee Office. For urgent cases, the results are typically faxed to the ordering provider as soon as possible by the treating provider. HIMS will continue conducting monthly reviews for the next two quarters to assure compliance.

Recommendation 8. We recommended that processes be strengthened to ensure that the blood usage and review process includes the results of proficiency testing.

Concur

Target date for completion: July 2013

Facility response: The past 12 months of Proficiency Testing (PT) results will be presented and discussed at the next quarterly Blood Transfusion Committee meeting in July 2013. The discussions will be documented in the committee minutes. All future PT results will be presented and discussed at the quarterly Blood Transfusion Committee meetings.

Recommendation 9. We recommended that processes be strengthened to ensure that EOC Committee minutes reflect that actions taken in response to identified deficiencies are tracked to closure.

Concur

Target date for completion: July 2013

Facility response: A tracking system has been in place since the beginning of FY 2013. Review of minutes for the current fiscal year will be conducted to identify items not tracked to completion and appropriately addressed. Items not closed will be added to agenda of next EOC meeting (June 17, 2013). Committee Chair and Coordinator will review agenda on a monthly basis, comparing it to previous minutes to ensure all items are carried over as "Old Business" on subsequent agendas until resolved.

Recommendation 10. We recommended that processes be strengthened to ensure that oxygen tanks are properly secured and stored in a manner that distinguishes between empty and full tanks.

Concur

Target date for completion: July 2013

Facility response: Weekly surveillance will be conducted to ensure proper storage and segregation of compressed gas tanks.

Recommendation 11. We recommended that processes be strengthened to ensure that soiled utility rooms are secured at all times.

Concur

Target date for completion: July 2013

Facility response: As many of the existing soiled utility rooms on the nursing units were never designed and constructed for lockable doors and door hardware, particularly at the Baltimore Medical Center, a Non-Recurring Maintenance (NRM) Construction project is being developed for funding and award of a construction contract. This project will replace existing door and door hardware where needed to provide adequate locking mechanisms on soiled utility rooms. In the interim, these soiled utility rooms will be added to EOC rounds, as well as PI tracer reviews. PI will provide education regarding the importance of being within a visible distance of the doors to ensure no unauthorized access to the soiled utility rooms to nurses who work in the area where these soiled utility rooms exist.

Recommendation 12. We recommended that processes be strengthened to ensure that EOC rounds are consistently conducted in the Annex building in accordance with VHA and local policy.

Concur

Target date for completion: July 2013

Facility response: The VAMHCS EOC Coordinator has taken appropriate action to add the clinical areas of the Annex building to the schedule to be completed twice per fiscal year in accordance with the VA regulations regarding EOC rounds. All areas of the

VAMHCS will now be rounded twice per year per 2007 guidance from the DUSHOM. The first is to occur by July 30, 2013.

Recommendation 13. We recommended that facility policy be amended to include that CS Coordinators must have complete understanding of CS policies and the VHA inspection process and to include requirements for new CS inspector orientation and/or annual training thereafter.

Concur

Target date for completion: August, 2013

Facility response: The current policy has been amended and will be sent out for concurrence by June 14, 2013 and once approved, it will be published.

Recommendation 14. We recommended that the instructions for inspecting automated dispensing machines be amended to include monthly CS inspector reconciliation of 1 day's dispensing activity and that compliance be monitored.

Concur

Target date for completion: September 2013

Facility response: For long term compliance the facility is purchasing Omnicell systems that will allow inspectors, pharmacy, and other users to reconcile dispensing to each unit. The purchase has been approved by Contracting. Once the system is installed and in place, VAMHCS will be compliant with this requirement. As an interim measure the facility will select a random day each month and reconcile the dispensing activity for a randomly selected zone. This process will be performed until the Omnicell arrives.

Recommendation 15. We recommended that processes be strengthened to ensure that monthly CS inspection findings summaries and quarterly trend reports provided to the facility Director include a complete list of the required inspections that were not conducted.

Concur

Target date for completion: Completed June 11, 2013

Facility response: The monthly and quarterly reports have been updated to include improved monitoring of missed zones and discrepancies. Reports are forwarded to the Medical Center Director through Executive Committee of Administrative Services (ECAS) and are discussed and documented in the committee minutes.

Recommendation 16. We recommended that processes be strengthened to ensure that all required non-pharmacy areas with CS are inspected and that compliance be monitored.

Concur

Target date for completion: October 2013

Facility response: At the beginning of the Fiscal Year, an incentive program will begin for all inspectors who complete 95% of their assigned inspections. Compliance will be monitored to identify all inspectors who achieve this goal. Incentives have proved effective as a VA best practice nationally and will alleviate the issues with missed zones due to inspector non-compliance and scheduling conflicts. The program has been developed and is awaiting Medical Center Director approval.

Recommendation 17. We recommended that processes be strengthened to ensure that non-HPC clinical staff who provide care to patients at the end of their lives receive end-of-life training.

Concur

Target date for completion: March 2014

Facility response: The facility will continue including the topic of Palliative Care as part of orientation for new employees. To ensure that all employees have a basic understanding of palliative care the decision has been made to require staff to take the online education module, "Leading the Way – VA Palliative Care" in the Talent Management System (TMS). A memorandum from the Medical Center Director will be distributed to the target employees by July 30, 2013 to promote completion of this course.

Recommendation 18. We recommended that the facility PU policy be revised to address prevention for outpatients and that compliance with the revised policy be monitored.

Concur

Target date for completion: December 2013

Facility response: The facility will revise the PU policy to include prevention of pressure ulcer for all outpatients according to VHA HANDBOOK 1180.02. Outpatient clinics will identify the process for pressure ulcer risk screening based on the population served. Once developed, the Certified Wound Care Nurse (CWCN) will provide education regarding use and process at staff meetings. Outpatient clinics will monitor screenings quarterly, and report results to Interdisciplinary Pressure Ulcer Committee.

Recommendation 19. We recommended that processes be strengthened to ensure that acute care staff consistently provide and document completion of recommended PU interventions and that compliance be monitored.

Concur

Target date for completion: December 2013

Facility response: The appropriate templates will be updated to include completion of any recommended interventions in CPRS (July 2013). The Wound Liaison/Wound Ostomy Care Nurse (WOCN) will provide education regarding use and process at staff meetings. Wound Liaison will perform walking rounds weekly for Veterans at risk for pressure ulcers to ensure pressure ulcer interventions are in place and documented according to the plan of care (September 2013). Wound Liaisons will provide findings to WOCN, who will report to the Interdisciplinary Pressure Ulcer Committee.

Recommendation 20. We recommended that processes be strengthened to ensure that acute care staff provide and document PU education for patients at risk for and with PUs and/or their caregivers and that compliance be monitored.

Concur

Target date for completion: December 2013

Facility response: The VAMHCS facility created nursing documentation template for patient/significant other education regarding wound/pressure ulcer etiology, treatments and prevention (completed, April 2013.) Wound Liaison/WOCN will provide education on the importance of completing this aspect of the template at staff meetings in August 2013. The Wound Liaisons will audit 10 charts per month of patients on their respective units with pressure ulcers on admission and/or discharge for evidence of education regarding pressure ulcer etiology, prevention or treatment for three months. Wound Liaisons will report findings to WOCN who will report to the Interdisciplinary Pressure Ulcer Committee quarterly.

Recommendation 21. We recommended that the facility establish staff PU education requirements and that compliance be monitored.

Concur

Target date for completion: December 2013

Facility response: Nursing staff will have mandatory staff education annually on pressure ulcer prevention and treatment according to VAMHCS policy. This requirement will be added to the VAMHCS Policy Memorandum 512-118-015. The Nurse Manager will monitor as part of the employees' annual evaluation.

Recommendation 22. We recommended that processes be strengthened to ensure that electrical medical equipment in PU patient rooms receives an electrical safety inspection and that compliance be monitored.

Concur

Target date for completion: June 2013

Facility response: Biomedical Engineering will perform initial incoming inspection on electrical medical equipment in patient rooms. Compliance will be monitored by tracking work order requests for incoming inspections. For medical equipment that falls under the equipment management program, follow up inspections will be performed based on the manufacturer's recommendation and historical data. As this process is ongoing the target date for implementation is June 2013.

Recommendation 23. We recommended that nursing managers ensure compliance with all elements of the staffing methodology that was implemented in December 2012.

Concur

Target date for completion: August 30, 2013

Facility response: The VAMHCS is compliant with the VHA directive 2010-034 for FY 2012. The expert panels are scheduled to conduct a reassessment during the months of June and July for FY 2013. The facility panel will be scheduled by August, 30, 2013. The monthly nurse leadership meetings are utilized to remind all nurse managers that the expert panels are to be reassessed, and a deadline date of July 30, 2013 has been provided to the Nurse leaders.

Recommendation 24. We recommended that the facility ensure that the multidisciplinary committee responsible for construction and renovation oversight includes all required members.

Concur

Target date for completion: July 2013

Facility response: A new policy, which dictates the composition of the committee, is in the review/concurrence process. The VAMHCS anticipates the policy will be published after a Collective Bargaining review (yet to be scheduled) is completed.

Recommendation 25. We recommended that processes be strengthened to ensure that tuberculosis risk assessments are conducted prior to construction project initiation.

Concur

Target date for completion: July 2013

Facility response: A new policy, which identifies the requirement for tuberculosis risk assessments, is in the review/concurrence process. The VAMHCS anticipates the policy will be published after a Collective Bargaining review (yet to be scheduled) is completed. The Infection Control Risk Assessment (ICRA) form has been modified to include the tuberculosis assessments as part of the ICRA.

Recommendation 26. 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 2013

Facility response: A new policy, which dictates approved training courses, is in the review/concurrence process. The VAMHCS anticipates the policy will be published after a Collective Bargaining review (yet to be scheduled) is completed.

OIG Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the OIG at (202) 461-4720.
Onsite Contributors	Sonia Whig, MS, LDN, Team Leader Gail Bozzelli, RN Donald Braman, RN Margie Chapin, RT (R), JD Jennifer Christensen, DPM David Griffith, BSN, RN Terri Julian, PhD Nelson Miranda, LCSW Molly Morgan Melanie Oppat, MEd, LDN
Other Contributors	Elizabeth Bullock Shirley Carlile, BA Paula Chapman, CTRS Lin Clegg, PhD Marnette Dhooghe, MS Matt Frazier, MPH Cynthia Gallegos Jeff Joppie, BS Victor Rhee, MHS Julie Watrous, RN, MS Jarvis Yu, MS

Report Distribution

VA Distribution

Office of the Secretary
Veterans Health Administration
Assistant Secretaries
General Counsel
Director, VA Capitol Health Care Network (10N5)
Director, VA Maryland Health Care System (512/00)

Non-VA Distribution

House Committee on Veterans' Affairs
House Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
House Committee on Oversight and Government Reform
Senate Committee on Veterans' Affairs
Senate Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
Senate Committee on Homeland Security and Governmental Affairs
National Veterans Service Organizations
Government Accountability Office
Office of Management and Budget
U.S. Senate: Benjamin L. Cardin, Barbara A. Mikulski
U.S. House of Representatives: Elijah Cummings, Andy Harris, Dutch Ruppersberger, John P. Sarbanes

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 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:
- VHA Directive 2011-007, *Required Hand Hygiene Practices*, February 16, 2011.
- VHA Directive 2009-004, *Use and Reprocessing of Reusable Medical Equipment (RME) in Veterans Health Administration Facilities*, February 9, 2009.
- VHA Directive 2009-026, *Location, Selection, Installation, Maintenance, and Testing of Emergency Eyewash and Shower Equipment*, May 13, 2009.
- VA National Center for Patient Safety, "Look-Alike Hemodialysis Solutions," Patient Safety Alert 11-09, September 12, 2011.
- VA National Center for Patient Safety, "Multi-Dose Pen Injectors," Patient Safety Alert 13-04, January 17, 2013.
- 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 Materiel Management, the Association for Professionals in Infection Control and Epidemiology.

[3] References used for this topic included:
- VHA Handbook 1108.01, *Controlled Substances (Pharmacy Stock)*, November 16, 2010.
- VHA Handbook 1108.02, *Inspection of Controlled Substances*, March 31, 2010.
- VHA Handbook 1108.05, *Outpatient Pharmacy Services*, May 30, 2006.
- 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 included:
- VHA Handbook 1180.02, *Prevention of Pressure Ulcers*, July 1, 2011 (corrected copy).
- Various requirements of The Joint Commission.
- Agency for Healthcare Research and Quality Guidelines.
- National Pressure Ulcer Advisory Panel Guidelines.
- The New York State Department of Health, et al., *Gold STAMP Program Pressure Ulcer Resource Guide*, November 2012.

[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] 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.