Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 13-00899-261

Combined Assessment Program Review of the Hunter Holmes McGuire VA Medical Center Richmond, Virginia

August 5, 2013

Washington, DC 20420

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

Glossary

CAP	Combined Assessment Program
CLC	community living center
CS	controlled substances
CSC	Controlled Substances Coordinator
ED	emergency department
EHR	electronic health record
EOC	environment of care
facility	Hunter Holmes McGuire VA Medical Center
FPPE	Focused Professional Practice Evaluation
FY	fiscal year
HPC	hospice and palliative care
IUS	immediate use sterilization
LIP	licensed independent practitioner
MEC	Medical Executive Committee
NA	not applicable
NC	noncompliant
OIG	Office of Inspector General
OR	operating room
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

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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 April 29, 2013.

Review Results: The review covered six activities. We made no recommendations in the following activity:

- Nurse Staffing

The facility's reported accomplishment was hosting the 32nd National Veterans Wheelchair Games in June 2012.

Recommendations: We made recommendations in the following five activities:

Quality Management: Consistently initiate Focused Professional Practice Evaluations for newly hired licensed independent practitioners, and consistently report results to the Medical Executive Committee. Scan non-VA purchased diagnostic test results into electronic health records.

Environment of Care: Ensure that patient care areas and furnishings are clean and that inpatient rooms and emergency department medical equipment are consistently terminally cleaned. Require that operating room employees who perform immediate use sterilization receive initial training.

Medication Management – Controlled Substances Inspections: Consistently conduct weekly inventories of automated dispensing machines. Ensure all required non-pharmacy areas with controlled substances are inspected.

Coordination of Care – Hospice and Palliative Care: Include a dedicated nursing representative on the Palliative Care Consult Team. Ensure all hospice and palliative care staff and other clinical staff who provide care to patients at the end of their lives receive end-of-life training.

Pressure Ulcer Prevention and Management: Perform and document a skin inspection and risk scale prior to discharge. Accurately document pressure ulcer location, stage, risk scale score, and date acquired. Perform and document daily skin inspections and risk scales for patients at risk for or with pressure ulcers. Provide and document pressure ulcer education for patients at risk for and with pressure ulcers and/or their caregivers.

Comments

The Veterans Integrated Service Network and Facility Directors agreed with the Combined Assessment Program review findings and recommendations and provided acceptable improvement plans. (See Appendixes C and D, pages 17–23, for the full text of the Directors' comments.) We consider recommendations 1, 5, and 8 closed. We will follow up on the planned actions for the open recommendations 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 six activities:

- QM
- EOC
- Medication Management – CS Inspections
- Coordination of Care – HPC
- PU Prevention and Management
- Nurse Staffing

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 Hunter Holmes McGuire VA Medical Center, Richmond, Virginia,* Report No. 10-02987-78, January 31, 2011).

During this review, we presented crime awareness briefings for 116 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 397 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

National Wheelchair Games

The National Veterans Wheelchair Games are an outgrowth of the VA's historic involvement in wheelchair sports. Wheelchair sports had their beginning after the aftermath of World War II, when young disabled veterans began playing basketball in VA hospitals. The first National Veterans Wheelchair Games were held in 1981 in Richmond, VA. That year, 74 veterans from 14 states competed. In 2012, the facility hosted the 32nd National Veterans Wheelchair Games June 24–30. Fifty-two planning committees were coordinated to ensure successful hosting and execution of the games for the athletes while managing the facility's operational needs. Five hundred and forty athletes from around the Nation competed in the games, and more than 3,000 community volunteers participated in events throughout the games.

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 LIPs complied with selected requirements.	Fifty-two profiles reviewed: • Seven FPPEs (13 percent) were not initiated. • Of the 45 FPPEs completed, results of 23 (51 percent) were not reported to the MEC.
	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, or the facility had reassessed observation criteria and proper utilization.	
	Staff performed continuing stay reviews on at least 75 percent of patients in acute beds.	
	Appropriate processes were in place to prevent incidents of surgical items being retained in a patient following surgery.	
	The cardiopulmonary resuscitation review policy and processes complied with requirements for reviews of episodes of care where resuscitation was attempted.	
	There was an EHR quality review committee, and the review process complied with selected requirements.	

NC	Areas Reviewed (continued)	Findings
	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.	Ten EHRs of patients who had non-VA purchased diagnostic tests reviewed: • Six test results were not scanned into the 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 FPPEs for newly hired LIPs are consistently initiated and that results are consistently reported to the MEC.

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

EOC

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

We inspected the hemodialysis, medicine, surgery, and locked mental health units; two intensive care units; the CLC; the ED; and SPS. Additionally, we reviewed relevant documents, conversed with key employees and managers, and reviewed 30 employee training and competency files (10 hemodialysis, 10 OR, 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
	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.	
	Fire safety requirements were met.	
X	Environmental safety requirements were met.	• In five of the seven patient care areas inspected, the floors and/or bases of bedside tables were not clean.
	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.	Local policies on cleaning and disinfection of non-critical RME, patient care items, and terminal room cleaning reviewed: • On the medical unit, staff did not consistently terminally clean inpatient rooms. In the ED, staff did not consistently terminally clean intravenous pumps, poles, and stretchers.
	Areas Reviewed for Hemodialysis	
	The facility had policy detailing the cleaning and disinfection of hemodialysis equipment and environmental surfaces and management of infection prevention precautions patients.	

NC	Areas Reviewed for Hemodialysis (continued)	Findings
	Monthly biological water and dialysate testing were conducted and included required components, and identified problems were corrected.	
	Employees received training on bloodborne pathogens.	
	Employee hand hygiene monitoring was conducted, and any needed corrective actions were implemented.	
	Selected EOC/infection prevention/safety requirements were met.	
	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 IUS (flash) and monitored it.	
	Employees received required RME training and competency assessment.	
X	OR employees who performed IUS (flash) received training and competency assessment.	• Of the four OR employees on duty for less than or equal to 2 years who performed IUS, there was no evidence that three received initial training.
	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

3. We recommended that processes be strengthened to ensure that patient care areas and furnishings are clean and that compliance be monitored.

4. We recommended that processes be strengthened to ensure that inpatient rooms and ED medical equipment are consistently terminally cleaned and that compliance be monitored.

5. We recommended that processes be strengthened to ensure that OR employees who perform IUS receive initial training.

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 CSCs 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
	Facility policy was consistent with VHA requirements.	
	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: • Although instructions required weekly inventories of automated dispensing machines, they were not consistently conducted.
	Monthly CS inspection findings summaries and quarterly trend reports were provided to the facility Director.	
	CSC position description(s) or functional statement(s) included duties, and CSC(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: • One monthly inspection was missed in three different non-pharmacy areas.
	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

6. We recommended that processes be strengthened to ensure that weekly inventories of automated dispensing machines are consistently conducted and that compliance be monitored.

7. 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 areas marked as NC needed improvement. Any 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: • A nursing representative had not been dedicated to the PCCT.
	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 four HPC staff had end-of-life training. • There was no evidence that 11 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.	

NC	Areas Reviewed (continued)	Findings
	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.	

Recommendations

8. We recommended that processes be strengthened to ensure that the PCCT includes a dedicated nursing representative.

9. We recommended that processes be strengthened to ensure that all HPC staff and other 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, 21 EHRs of patients with PUs (6 patients with hospital-acquired PUs, 10 patients with community-acquired PUs, and 5 patients with PUs at the time of our onsite visit), and 10 employee training records. Additionally, we inspected one patient room. 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
	The facility had a PU prevention policy, and it addressed prevention for all inpatient areas and for outpatient care.	
	The facility had an interprofessional 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.	
X	Skin inspections and risk scales were performed upon transfer, change in condition, and discharge.	• Four of the 16 applicable patients did not have a skin inspection and risk scale performed prior to discharge.
X	Staff were generally consistent in documenting location, stage, risk scale score, and date acquired.	• For 11 of the 19 applicable patients, staff were inconsistent in documentation of PU location, stage, risk scale score, and date acquired.
X	Required activities were performed for patients determined to be at risk for PUs and for patients with PUs.	• Two of the six applicable patients at risk for PUs did not consistently have daily skin assessments performed and documented. • Eight of the 19 applicable patients at risk for or with PUs did not consistently have daily risk scales performed and documented.
	Required activities were performed for patients determined to not be at risk for PUs.	
	For patients at risk for and with PUs, interprofessional treatment plans were developed, interventions were recommended, and EHR documentation reflected that 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.	

NC	Areas Reviewed	Findings
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: • None of the three applicable EHRs contained evidence that PU education was provided to the patient and/or their caregiver.
	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 complied with selected fire and environmental safety, infection prevention, and medication safety and security requirements in PU patient rooms.	
	The facility complied with any additional elements required by VHA or local policy.	

Recommendations

10. We recommended that processes be strengthened to ensure that acute care staff perform and document a skin inspection and risk scale prior to discharge and that compliance be monitored.

11. We recommended that processes be strengthened to ensure that acute care staff accurately document PU location, stage, risk scale score, and data acquired and that compliance be monitored.

12. We recommended that processes be strengthened to ensure that acute care staff perform and document daily skin inspections and risk scales for patients at risk for or with PUs and that compliance be monitored.

13. 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.

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 mental health).[6]

We reviewed relevant documents and 24 training files, and we conversed with key employees. Additionally, we reviewed the actual nursing hours per patient day for acute medical/surgical unit 4C, CLC unit 1N, and mental health unit 1F 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. Any items that did not apply to this facility are marked NA. The facility generally met requirements. We made no recommendations.

NC	Areas Reviewed	Findings
	The facility completed the required steps to develop a nurse staffing methodology by the deadline.	
	The unit-based expert panels followed the required processes and included all required members.	
	The facility expert panel followed the required processes and included all required members.	
	Members of the expert panels completed the required training.	
	The actual nursing hours per patient day met or exceeded the target nursing hours per patient day.	
	The facility complied with any additional elements required by VHA or local policy.	

Facility Profile (Richmond/652) FY 2013 through March 2013[a]	
Type of Organization	Tertiary
Complexity Level	1a
Affiliated/Non-Affiliated	Affiliated
Total Medical Care Budget in Millions	$407.4
Number of:	
• **Unique Patients**	38,978
• **Outpatient Visits**	259,170
• **Unique Employees**[b]	2,277
Type and Number of Operating Beds (through February 2013):	
• **Hospital**	294
• **CLC**	98
• **Mental Health**	23
Average Daily Census (through February 2013):	
• **Hospital**	172
• **CLC**	67
• **Mental Health**	6
Number of Community Based Outpatient Clinics	3
Location(s)/Station Number(s)	Fredericksburg/652GA Charlottesville/652GE Emporia/652GF
VISN Number	6

[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	54.2	59.0	54.7	51.1	48.5	55.4
VISN	59.5	64.6	49.7	49.7	49.7	51.5
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	16.3	12.2	13.2	21.1	26.4	21.8
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: July 12, 2013

From: Director, VA Mid-Atlantic Health Care Network (10N6)

Subject: **CAP Review of the Hunter Holmes McGuire VA Medical Center, Richmond, VA**

To: Director, Washington, DC, Office of Healthcare Inspections (54DC)

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

I have reviewed the draft CAP Review report of the Hunter Holmes McGuire VAMC. I concur with the findings and the response by the facility.

Please contact me at 919-956-5541 if there are any questions.

(original signed by:)
Daniel F. Hoffmann, FACHE
Network Director (VISN 6)

Facility Director Comments

Department of Veterans Affairs **Memorandum**

Date: July 11, 2013

From: Director, Hunter Holmes McGuire VA Medical Center (652/00)

Subject: **CAP Review of the Hunter Holmes McGuire VA Medical Center, Richmond, VA**

To: Director, VA Mid-Atlantic Health Care Network (10N6)

I have reviewed the findings from the CAP Review of the Hunter Holmes McGuire VAMC and I concur with the findings and the response as follows. The facility response and action plans are attached. If there are any questions, please contact R. Crystal Polatty, MD at 804-675-5000.

(original signed by:)
John A. Brandecker
Director

Comments to OIG's Report

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

OIG Recommendations

Recommendation 1. We recommended that processes be strengthened to ensure that FPPEs for newly hired LIPs are consistently initiated and that results are consistently reported to the MEC.

Concur

Target date for completion: Completed October 2012

Facility response: The data for LIP FPPE's pulled for review was from 2011. The facility self-identified the issue prior to the survey. In FY 13 a new tracking process was developed to assure that FPPE's were initiated and reported as appropriate for all new LIP's after Enter on Duty (EOD) date. The current spreadsheet has been furnished to OIG. The FPPE's have been presented to the Medical Executive Board for at least 4 months.

Recommendation 2. 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: September 30, 2013

Facility response: The documentation required is for emergent care that is not pre-approved by the facility and is managed by the VISN 6 Centralized Fee Unit (CFU). VISN 6 staff will develop a process with the CFU to ensure that the facility receives medical records to scan into CPRS. The VISN Centralized program will send all names of non-VA emergent paid cases to the facility. The number of cases will be the denominator and the number of records scanned into CPRS will be the numerator. Data will be reported to QEB until >90% for at least 3 months.

Recommendation 3. We recommended that processes be strengthened to ensure that patient care areas and furnishings are clean and that compliance be monitored.

Concur

Target date for completion: July 15, 2013

Facility response:

1. Infection Control Guidelines for the daily cleaning of patient rooms were revised and adopted by the Infection Control Committee. A checklist was developed and placed on the OIG shared site.
2. All EMS personnel were retrained on the proper cleaning of patient rooms according to the revised guidelines. This training was completed on 6/17/2013.

Compliance monitoring:

1. EMS supervisors will monitor overall cleanliness and furnishings' appearance by direct observation of EMS compliance with the daily checklist. Results of this monitor and the usual EOC rounds will be presenting monthly at the EOC meeting.
2. Results of compliance with the checklist will be presented to QEB until > 90% compliance for a minimum of 3 months.

Recommendation 4. We recommended that processes be strengthened to ensure that inpatient rooms and ED medical equipment are consistently terminally cleaned and that compliance be monitored.

Concur

Target date for completion: July 15, 2013 for EMS action and July 12, 2013 for SPS action.

Facility response:

1. Infection Control Guidelines for the cleaning of patient rooms including terminal cleaning were revised and adopted by the Infection Control Committee.
2. All EMS personnel were retrained on the proper cleaning of patient rooms according to the revised guidelines and checklist. This training was completed on 6/17/2013.
3. Revised procedures for the cleaning of IV pumps and poles were developed that include cleaning of all pumps by SPS personnel, standard delivery of cleaned pumps to clinical areas including ER by logistics personnel, and defined roles of nursing in the proper use and cleaning IV pumps and poles. Memorandum of "Proper Disinfection of Alaris Pumps" and Poles to be issued and staff educated on new protocol. The memo has been provided to the OIG. Nurse managers were educated on the new policy on July 11, 2013.

Compliance monitoring:

EMS actions:

1. EMS supervisors began ATP luminometer testing of rooms that have undergone terminal cleaning as of June 20, 2013. Rooms with high values (>200) will be immediately re-cleaned. Results of ATP testing will be summarized and presented by EMS at the Infection Control Committee meeting monthly.

2. Results will be presented to QEB monthly until > 90 % compliance for at least 3 months.

SPS actions:

1. IV Pumps and poles. SPS will deliver all pumps covered with plastic and initialed by the SPS employee. Compliance will be monitored by RME rounds twice a month and routinely reported to RME committee and Infection Control. Results will be reported to QEB monthly until >90% for at least 3 months.

Recommendation 5. We recommended that processes be strengthened to ensure that OR employees who perform IUS receive initial training.

Concur

Target date for completion: Completed May 8, 2013.

Facility response: 100% of OR nurses have completed training. Any new staff will demonstrate competency prior to performing IUS.

Recommendation 6. We recommended that processes be strengthened to ensure that weekly inventories of automated dispensing machines are consistently conducted and that compliance be monitored.

Concur

Target date for completion: August 30, 2013

Facility response: Nursing staff will be educated on performing weekly inventories of the automated dispensing machines. The Controlled Substance Coordinators will send the report to the Associate Director of Patient Care Services (ADPCS) monthly for appropriate intervention. The Controlled Substance Coordinators will monitor monthly as is required. Reports will be submitted to QEB monthly until compliance is at 90% or greater for at least 3 months.

Recommendation 7. 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: Completed March 1, 2013.

Facility response: The facility self-identified the issue prior to the survey. The importance of completing inspections was reviewed with staff prior to the OIG CAP survey. Since March of 2013, compliance with non-Pharmacy inspections has been 100%. Reports will continue monthly and percent compliance reported to the QEB until closure of the recommendation.

Recommendation 8. We recommended that processes be strengthened to ensure that the PCCT includes a dedicated nursing representative.

Concur

Target date for completion: Completed July 3, 2013.

Facility response: The facility self-identified the issue prior to the survey. The position of NP for Hospice and Palliative Care had been under recruitment and hired prior to the CAP survey. The employee entered on duty July 3, 2013 and will serve on the PCCT.

Recommendation 9. We recommended that processes be strengthened to ensure that all HPC staff and other clinical staff who provide care to patients at the end of their lives receive end-of-life training.

Concur

Target date for completion: September 30, 2013

Facility response: All clinical staff will have appropriate TMS modules added to their training. Goal is for >90% of applicable staff to have the training. Education Service Line (ESL) will monitor TMS and report monthly to QM until >90% compliance has been achieved for a minimum of 3 months.

Recommendation 10. We recommended that processes be strengthened to ensure that acute care staff perform and document a skin inspection and risk scale prior to discharge and that compliance be monitored.

Concur

Target date for completion: September 30, 2013

Facility response: Acute care staff will be re-educated on requirement to complete skin inspection and risk scale prior to discharge. Compliance will be monitored and reported to QEB monthly until >90% each month for at least 3 months.

Recommendation 11. We recommended that processes be strengthened to ensure that acute care staff accurately document PU location, stage, risk scale score, and data acquired and that compliance be monitored.

Concur

Target date for completion: September 30, 2013

Facility response: Acute care staff will be re-educated on PU location, stage, risk scale score, and date acquired. Compliance will be monitored by chart review and reported monthly to QEB until >90% compliance for at least 3 months. Compliance will be

monitored by chart review and reported to QEB monthly until > 90% each month for at least 3 months.

Recommendation 12. We recommended that processes be strengthened to ensure that acute care staff perform and document daily skin inspections and risk scales for patients at risk for or with PUs and that compliance be monitored.

Concur

Target date for completion: September 30, 2013

Facility response: Acute care staff will be re-educated on daily skin inspections and risk scales for patients at risk for or with PUs. Compliance will be monitored by chart reviews and reported monthly to QEB until >90% compliance for at least 3 months.

Recommendation 13. 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: September 30, 2013

Facility response: Education will be provided to acute care staff on education and materials for use with patients. The acute care staff who receives the patient with a high risk score or a PU is responsible for providing appropriate education to the patient and caregivers, providing written information, and documenting the education given. Compliance will be monitored by chart review and reported to QEB monthly until >90% for at least 3 months.

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Endnotes

[1] References used for this topic included:
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- Agency for Healthcare Research and Quality Guidelines.
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