Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 13-01670-269

Combined Assessment Program Review of the Jack C. Montgomery VA Medical Center Muskogee, Oklahoma

August 7, 2013

Washington, DC 20420

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

Glossary

CAP	Combined Assessment Program
CHF	congestive heart failure
CLC	community living center
COC	coordination of care
CS	controlled substances
EHR	electronic health record
EOC	environment of care
facility	Jack C. Montgomery VA Medical Center
FY	fiscal year
HPC	hospice and palliative care
MH	mental health
NA	not applicable
NC	noncompliant
OIG	Office of Inspector General
PCCT	Palliative Care Consult Team
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 June 10, 2013.

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

- Quality Management
- Environment of Care

The facility's reported accomplishment was congestive heart failure systems redesign.

Recommendations: We made recommendations in the following four activities:

Medication Management – Controlled Substances Inspections: Ensure that VA Police conduct annual physical security surveys of all pharmacy areas and that any identified deficiencies are corrected.

Coordination of Care – Hospice and Palliative Care: Include an administrative support person and a dedicated psychologist or other mental health professional on the Palliative Care Consult Team. Ensure that 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: Revise the facility pressure ulcer policy to address prevention for outpatients. Ensure acute care staff accurately document location, stage, risk scale score, and date pressure ulcer was acquired for all patients with pressure ulcers. Provide and document recommended pressure ulcer interventions. Ensure all patients discharged with pressure ulcers have wound care follow-up plans. Provide and document pressure ulcer education for patients at risk for and with pressure ulcers and/or their caregivers.

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

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 15–20, for the full text of the Directors' comments.) We will follow up on the planned actions until they are completed.

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

Objectives and Scope

Objectives

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

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

Scope

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

- QM
- EOC
- Medication Management – CS Inspections
- COC – HPC
- Pressure Ulcer 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 June 13, 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 Jack C. Montgomery VA Medical Center, Muskogee, Oklahoma,* Report No. 09-00732-124, May 12, 2009).

During this review, we presented crime awareness briefings for 496 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 342 responded. We shared summarized results with the facility Director.

In this report, we make recommendations for improvement. Recommendations pertain to issues that are significant enough to be monitored by the OIG until corrective actions are implemented.

Reported Accomplishment

CHF Systems Redesign

A systems redesign team participated in the VISN 16 Transitional Care Collaborative to reduce CHF readmissions by providing education to CHF patients, ensuring patients are well informed, and improving COC. The team created a CHF Self-Management Handbook to educate patients on the disease, medications, diet, and exercise. Patient Aligned Care Teams used "teach-back" education with patients/caregivers to ensure their understanding of the disease, prognosis, and self-care requirements. The facility implemented 2-day post-discharge follow-up phone calls to assess post-discharge needs and piloted weekly follow-up assessment calls for 5 consecutive weeks post discharge. Case management performed a high-risk needs assessment and an education gap analysis on each readmitted patient to determine the reason for readmission. The team assessed the CHF readmission rates and assigned patients readmitted within 30 days of discharge to the discharging provider/team. The facility completed the implementation of the redesign in September 2012. As a result, the facility's number of CHF 30-day readmissions for the 1st and 2nd quarters of FY 2013 was 8 patients, down from 32 patients in FY 2011.

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. 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
	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.	
	Focused Professional Practice Evaluations for newly hired licensed independent practitioners complied with selected requirements.	
	Local policy for the use of observation beds complied with selected requirements.	
	Data regarding appropriateness of observation bed use was gathered, and conversions to acute admissions were less than 30 percent, or the facility had reassessed observation criteria and proper utilization.	
	Staff performed continuing stay reviews on at least 75 percent of patients in acute beds.	
	Appropriate processes were in place to prevent incidents of surgical items being retained in a patient following surgery.	
	The cardiopulmonary resuscitation review policy and processes complied with requirements for reviews of episodes of care where resuscitation was attempted.	
	There was an EHR quality review committee, and the review process complied with selected requirements.	
	The EHR copy and paste function was monitored.	

NC	Areas Reviewed (continued)	Findings
	Appropriate quality control processes were in place for non-VA care documents, and the documents were scanned into EHRs.	
	Use and review of blood/transfusions complied with selected requirements.	
NA	CLC minimum data set forms were transmitted to the data center with the required frequency.	
NA	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.	

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 five inpatient units (medical/surgical, HPC, MH, rehabilitation, and intensive care), one outpatient clinic, the emergency department, and SPS. Additionally, we reviewed relevant documents, conversed with key employees and managers, and reviewed eight SPS employee training and competency files. 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 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.	
	Environmental safety requirements were met.	
	Infection prevention requirements were met.	
	Medication safety and security requirements were met.	
	Sensitive patient information was protected, and patient privacy requirements were met.	
	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.	
	Areas Reviewed for 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 was conducted and included required components, and identified problems were corrected.	
NA	Employees received training on bloodborne pathogens.	

NC	Areas Reviewed for Hemodialysis (continued)	Findings
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.	
NA	The facility had policies/procedures/guidelines for immediate use (flash) sterilization and monitored it.	
	Employees received required RME training and competency assessment.	
NA	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.	

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 the CS Coordinator and 10 CS inspectors and inspection documentation from 9 CS areas, the inpatient and outpatient pharmacies, and the emergency drug cache. The table below shows the areas reviewed for this topic. The area marked as NC needed improvement. Any items that did not apply to this facility are marked NA.

NC	Areas Reviewed	Findings
	Facility policy was consistent with VHA requirements.	
X	VA police conducted annual physical security surveys of the pharmacy/pharmacies, and any identified deficiencies were corrected.	• Annual physical security surveys of the pharmacy areas were not conducted.
	Instructions for inspecting automated dispensing machines were documented, included all required elements, and were followed.	
	Monthly CS inspection findings summaries and quarterly trend reports were provided to the facility Director.	
	CS Coordinator position description(s) or functional statement(s) included duties, and CS Coordinator(s) completed required certification and were free from conflicts of interest.	
	CS inspectors were appointed in writing, completed required certification and training, and were free from conflicts of interest.	
	Non-pharmacy areas with CS were inspected in accordance with VHA requirements, and inspections included all required elements.	
	Pharmacy CS inspections were conducted in accordance with VHA requirements and included all required elements.	
	The facility complied with any additional elements required by VHA or local policy.	

Recommendation

1. We recommended that processes be strengthened to ensure that VA Police conduct annual physical security surveys of the pharmacy areas and that any identified deficiencies be corrected.

COC – HPC

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

We reviewed relevant documents, 20 EHRs of patients who had PCCT consults (including 10 HPC inpatients), and 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: • An administrative support person had not been dedicated to the PCCT. • A psychologist or other MH professional 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 nine 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.	
NA	The CLC-based hospice program offered bereavement services.	
	The HPC consult contained the word "palliative" or "hospice" in the title.	
	HPC consults were submitted through the Computerized Patient Record System.	
	The PCCT responded to consults within the required timeframe and tracked consults that had not been acted upon.	
	Consult responses were attached to HPC consult requests.	
	The facility submitted the required electronic data for HPC through the VHA Support Service Center.	
	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

2. We recommended that processes be strengthened to ensure that the PCCT includes an administrative support person and a dedicated psychologist or other MH professional.

3. 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.

Pressure Ulcer Prevention and Management

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

We reviewed relevant documents, 25 EHRs of patients with pressure ulcers (10 patients with hospital-acquired pressure ulcers, 10 patients with community-acquired pressure ulcers, and 5 patients with pressure ulcers 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 pressure ulcer prevention policy, and it addressed prevention for all inpatient areas and for outpatient care.	Facility pressure ulcer prevention policy reviewed: • The policy did not address prevention for outpatients.
	The facility had an interprofessional pressure ulcer committee, and the membership included a certified wound care specialist.	
	Pressure ulcer 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.	
X	Staff were generally consistent in documenting location, stage, risk scale score, and date acquired.	• In 12 of the 25 EHRs, staff did not consistently document the location, stage, risk scale score, and/or date acquired.
	Required activities were performed for patients determined to be at risk for pressure ulcers and for patients with pressure ulcers.	
	Required activities were performed for patients determined to not be at risk for pressure ulcers.	
X	For patients at risk for and with pressure ulcers, interprofessional treatment plans were developed, interventions were recommended, and EHR documentation reflected that interventions were provided.	• Eight of the 25 EHRs did not contain evidence that the recommended interventions were provided.
X	If the patient's pressure ulcer was not healed at discharge, a wound care follow-up plan was documented, and the patient was provided appropriate dressing supplies.	• Eight of the applicable 20 EHRs did not contain evidence of wound care follow-up plans at discharge.

NC	Areas Reviewed (continued)	Findings
X	The facility defined requirements for patient and caregiver pressure ulcer education, and education on pressure ulcer prevention and development was provided to those at risk for and with pressure ulcers and/or their caregivers.	Facility pressure ulcer patient and caregiver education requirements reviewed: • For 16 of the patients at risk for/with a pressure ulcer, EHRs did not contain evidence that education was provided.
	The facility defined requirements for staff pressure ulcer education, and acute care staff received training on how to administer the pressure ulcer 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 pressure ulcer patient rooms.	
	The facility complied with any additional elements required by VHA or local policy.	

Recommendations

4. We recommended that the facility pressure ulcer policy be revised to address prevention for outpatients and that compliance with the revised policy be monitored.

5. We recommended that processes be strengthened to ensure that acute care staff accurately document location, stage, risk scale score, and date pressure ulcer was acquired for all patients with pressure ulcers and that compliance be monitored.

6. We recommended that processes be strengthened to ensure that acute care staff provide and document recommended pressure ulcer interventions and that compliance be monitored.

7. We recommended that processes be strengthened to ensure that all patients discharged with pressure ulcers have wound care follow-up plans and that compliance be monitored.

8. We recommended that processes be strengthened to ensure that acute care staff provide and document pressure ulcer education for patients at risk for and with pressure ulcers 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 MH).[6]

We reviewed relevant documents and conversed with key employees. The table below shows the areas reviewed for this topic. The area marked as NC needed improvement. 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.	• The staffing methodology was not implemented until December 6, 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

9. We recommended that nursing managers monitor the staffing methodology that was implemented in December 2012.

Facility Profile (Muskogee/623) FY 2013 through May 2013[a]	
Type of Organization	Secondary
Complexity Level	2-Medium complexity
Affiliated/Non-Affiliated	Affiliated
Total Medical Care Budget in Millions	$214.5
Number (through June 2013) of:	
• **Unique Patients**	33,986
• **Outpatient Visits**	305,488
• **Unique Employees**[b]	1,292
Type and Number of Operating Beds:	
• **Hospital**	99
• **CLC**	NA
• **MH**	14
Average Daily Census:	
• **Hospital**	58
• **CLC**	NA
• **MH**	10.8
Number of Community Based Outpatient Clinics	3
Location(s)/Station Number(s)	Tulsa/623BY Hartshorne/623GA Vinita/623GB
VISN Number	16

[a] All data is for FY 2013 through May 2013 except where noted.
[b] Unique employees involved in direct medical care (cost center 8200).

VHA Patient Satisfaction Survey

VHA has identified patient satisfaction scores as significant indicators of facility performance. Patients are surveyed monthly. Table 1 below shows facility, VISN, and VHA overall inpatient and outpatient satisfaction scores for FY 2012.

Table 1

	Inpatient Scores		Outpatient Scores			
	FY 2012		FY 2012			
	Inpatient Score Quarters 1–2	Inpatient Score Quarters 3–4	Outpatient Score Quarter 1	Outpatient Score Quarter 2	Outpatient Score Quarter 3	Outpatient Score Quarter 4
Facility	71.8	69.0	52.1	55.1	50.4	54.7
VISN	64.1	64.3	52.3	50.9	50.6	50.8
VHA	63.9	65.0	55.0	54.7	54.3	55.0

Hospital Outcome of Care Measures

Hospital Outcome of Care Measures show what happened after patients with certain conditions received hospital care.[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	14.6	10.3	13.8	19.2	28.3	25.1
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 18, 2013

From: Director, South Central VA Health Care Network (10N16)

Subject: **CAP Review of the Jack C. Montgomery VA Medical Center, Muskogee, OK**

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

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

1. The South Central VA Health Care Network (VISN 16) has reviewed and concurs with the findings and the responses submitted by the Jack C. Montgomery VA Medical Center, Muskogee, OK.

2. If you have questions regarding the information submitted, please contact Reba T. Moore, VISN 16 Accreditation Specialist, at 601-206-7022.

Rica Lewis-Payton, MHA, FACHE

Facility Director Comments

Department of Veterans Affairs **Memorandum**

Date: July 12, 2013

From: Director, Jack C. Montgomery VA Medical Center (623/00)

Subject: **CAP Review of the Jack C. Montgomery VA Medical Center, Muskogee, OK**

To: Director, South Central VA Health Care Network (10N16)

1. We have reviewed and concur with the preliminary report of the Combined Assessment Program review of the Jack C. Montgomery VAMC. We have developed an action plan and have begun implementing our plan.

2. If there are any questions or concerns please contact Martha Hardesty RN, Performance Improvement Specialist at 918-577-3473.

James R. Floyd, FACHE
Medical Center 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 VA Police conduct annual physical security surveys of the pharmacy areas and that any identified deficiencies be corrected.

Concur

Target date for completion: July 11, 2013

Facility response: Two detectives have physical security duties in their Position Description and these officers have been to Physical Security training at the Law Enforcement Training Center in Little Rock Arkansas. They are responsible for creating the schedule of security checks and informing the Chief of Police and Associate Director in writing when the physical security checks will be completed. They are also responsible for notifying the Chief of Police and the Associate Director in writing of any findings associated with the physical security audits. Physical security survey was completed on the pharmacy on May 31, 2013.

Recommendation 2. We recommended that processes be strengthened to ensure that the PCCT includes an administrative support person and a dedicated psychologist or other MH professional.

Concur

Target date for completion: August 31, 2013

Facility response: A psychologist has been identified to work with the PCCT at 0.5 FTEE. This will be placed into her functional statement. An administrative support person has been identified to assist with the PCCT at 0.25 FTEE. Effective date for both roles is August 31, 2013.

Recommendation 3. 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: July 31, 2013

Facility response: Education service reports 100% of the PCCT has had end-of-life training in Talent Management System (TMS) (module # VA16188). Training for all

inpatient nursing is being accomplished via the Hospice Education Network through the End-of-Life Nursing Education Consortium (ELNEC). Approximately 50% of assigned nurses have received this training and the rest have a completion deadline of July 31, 2013. Education Service has set up the PCCT and all assigned nurses to take the TMS module on End-of-Life Training yearly. TMS prompts the student and supervisor annually and places the module on the student's mandatory education list.

Recommendation 4. We recommended that the facility pressure ulcer policy be revised to address prevention for outpatients and that compliance with the revised policy be monitored.

Concur

Target date for completion: October 31, 2013

Facility response: Patient Care Services Standard Operating Procedure (SOP) 118-8, Prevention and Management of Pressure Ulcers, will be changed to a Medical Center Memorandum (MCM) and will include prevention for outpatients. This MCM will be distributed to all Primary Care staff. Compliance monitoring will be done by Nurse Managers via a monthly audit of outpatient visits at all CBOC's and parent facility for 90 days.

Recommendation 5. We recommended that processes be strengthened to ensure that acute care staff accurately document location, stage, risk scale score, and date pressure ulcer was acquired for all patients with pressure ulcers and that compliance be monitored.

Concur

Target date for completion: October 31, 2013

Facility response: Nursing Service will implement a 5-point plan which includes computer documentation prompts, staff education and coaching, ready references, and visual cues at computer stations. Monitoring will be completed through monthly Medical Record Review audits of 5 records for each acute care setting per month for 90 days. The medical record review audit form has been revised to include pressure ulcer documentation. The medical records audit data is reported to the Medical Records Committee and Executive Committee of the Medical Staff quarterly.

Recommendation 6. We recommended that processes be strengthened to ensure that acute care staff provide and document recommended pressure ulcer interventions and that compliance be monitored.

Concur

Target date for completion: October 31, 2013

Facility response: The Nursing reassessment template is designed where interventions are documented every shift. There is also a separate Pressure Ulcer Plan of Care template that describes interventions that are carried out by the nursing staff. Staff will be educated by Nurse Managers on documentation of interventions and compliance. Monitoring will be completed through Monthly Medical Records Review. Each inpatient acute care setting will complete 5 record audits per month for 90 days. The medical record review audit form has been revised to include pressure ulcer documentation. The medical records audit data is reported to the Medical Records Committee and Executive Committee of the Medical Staff quarterly.

Recommendation 7. We recommended that processes be strengthened to ensure that all patients discharged with pressure ulcers have wound care follow-up plans and that compliance be monitored.

Concur

Target date for completion: October 31, 2013

Facility response: The wound care follow-up plan of care will be added to the providers Discharge Instructions template so the provider may choose the type of follow-up for the patient. These instructions are sent home with the patient or care giver in hard copy which the nurse reviews with the patient before discharge. Monitoring will be completed through Monthly Medical Records Review. Each inpatient acute care setting will complete 5 record audits per month for 90 days. The medical record review audit form has been revised to include pressure ulcer documentation. The medical records audit data is reported to the Medical Records Committee and Executive Committee of the Medical Staff quarterly.

Recommendation 8. We recommended that processes be strengthened to ensure that acute care staff provide and document pressure ulcer education for patients at risk for and with pressure ulcers and/or their caregivers and that compliance be monitored.

Concur

Target date for completion: October 31, 2013

Facility response: Nursing staff documents pressure ulcer education to patients/caregivers every 12 hours in their Nursing Reassessment Template. The facility developed a Multidisciplinary Education Template in 2010. Nurse Managers and Education Service will again provide staff education to all inpatient staff on use of this template. The Clinical Applications Coordinators will place a list of wound care interventions into the Provider Discharge Instructions template. The providers then will be able to choose which of these interventions should be done by the patient/care giver at home. Monitoring will be completed through Monthly Medical Records Review. Each inpatient acute care setting will complete 5 record audits per month for 90 days.

Recommendation 9. We recommended that nursing managers monitor the staffing methodology that was implemented in December 2012.

Concur

Target date for completion: July 10, 2013

Facility response: Staffing Methodology is now a standing agenda item on the Unit Based Counsel staff meeting held monthly. Staffing Methodology will be placed on the Nurse Manager agenda as a standing agenda item. The Facility has completed the 2013 Staffing Methodology at the Unit Based Level and is now presenting at the Facility Expert Panel Level. All staffs participating in the 2013 Staffing Methodology at the Unit Based Level and Expert Facility Level have completed the TMS Educational Modules. Staffing is discussed and reviewed daily by all Nurse Managers to ensure that staffing is adequate throughout the acute care settings on the inpatient units to comply with Nursing Hours per Patient Day (NHPPD). This includes the Charge Nurses, Assistant Nurse Managers, Nursing Officers of the Day (NOD), and Nurse Managers assisting on the units when necessary to meet the requirements for safe patient care. A Staffing Methodology report is presented in the Quality Management Council on a monthly basis. The facility is in compliance with all other additional elements required by VHA or local policy in concordance with the Staffing Methodology Data process for 2013.

OIG Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the OIG at (202) 461-4720.
Onsite Contributors	Josephine Biley Andrion, RN, MHA, Team Leader Elizabeth Burns, MSSW Francis Keslof, EMT, MHA Sandra Khan, RN, BSN Judy Montano, MS Glen Pickens, RN, MHSM Julie Watrous, RN, MS James Werner Katrina Young, RN, MSHL
Other Contributors	Elizabeth Bullock Shirley Carlile, BA Paula Chapman, CTRS Lin Clegg, PhD Marnette Dhooghe, MS Matt Frazier, MPH, MBA Deborah Howard, RN, MSN Derrick Hudson Jeff Joppie, BS Victor Rhee, MHS Jarvis Yu, MS

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Office of Management and Budget
U.S. Senate: Tom Coburn, James M. Inhofe
U.S. House of Representatives: Jim Bridenstine, Markwayne Mullin

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

Endnotes

[1] References used for this topic included:
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