Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 13-01671-262

Combined Assessment Program Review of the Sheridan VA Healthcare System Sheridan, Wyoming

August 9, 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
CLC	community living center
CS	controlled substances
ECC	Emergency Care Committee
EHR	electronic health record
EOC	environment of care
facility	Sheridan VA Healthcare System
FY	fiscal year
HPC	hospice and palliative care
MEB	Medical Executive Board
NA	not applicable
NC	noncompliant
OIG	Office of Inspector General
PCCT	Palliative Care Consult Team
QM	quality management
RME	reusable medical equipment
SOP	standard operating procedure
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 May 6, 2013.

Review Results: The review covered six activities. The facility's reported accomplishment was the achievement of an employee flu vaccination rate of 76 percent compared to the national average of 48 percent.

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

Quality Management: Ensure Emergency Care Committee membership includes all required disciplines. Review the quality of entries in the electronic health record (EHR). Consistently scan results of non-VA purchased care into EHRs.

Environment of Care: Report results of compliance with reusable medical equipment (RME) standard operating procedures to the RME Management Committee and the Medical Executive Board. Ensure that Sterile Processing Service employees responsible for reprocessing activities receive initial RME training and annual competency assessments. Require that manufacturers' instructions are available for all RME items and that RME is reprocessed at the specified temperature. Ensure Sterile Processing Service sterile storage area temperature and humidity levels are consistently monitored and maintained within acceptable levels.

Medication Management – Controlled Substances Inspections: Amend facility policy to include the requirement that controlled substances (CS) inspectors receive annual updates, and ensure inspectors receive those updates. Develop instructions for inspections of automated dispensing machines. Ensure that monthly findings summaries are provided to the facility Director and that quarterly trend reports clearly summarize discrepancies and problematic trends and identify potential areas for improvement. Require that CS inspectors' appointments state the end date of their term and that CS inspectors' terms do not exceed 3 years. Ensure monthly inspections of all pharmacy and non-pharmacy areas with CS are conducted in accordance with Veterans Health Administration requirements and include all required elements.

Coordination of Care – Hospice and Palliative Care: Include a dedicated administrative support person on the Palliative Care Consult Team. Ensure all non-hospice and palliative care (HPC) clinical staff who provide care to patients at the end of their lives receive end-of-life training. Establish a process to track HPC consults that are not acted upon within 7 days of the request. Consistently assess HPC inpatients' pain whenever vital signs are obtained, and document results in EHRs. Document HPC inpatients' pain assessments in EHRs using approved note titles.

Pressure Ulcer Prevention and Management: Include a certified wound care specialist on the interprofessional pressure ulcer committee. Ensure acute care staff consistently document pressure ulcer location and stage and perform and document all required daily activities/inspections for patients with pressure ulcers. Require acute care staff to provide and document recommended pressure ulcer interventions and to perform and document skin inspections and risk scales at discharge. Ensure all patients discharged with pressure ulcers have wound care follow-up plans and receive dressing supplies prior to discharge. Provide and document pressure ulcer education for patients and/or their caregivers. Establish staff pressure ulcer education requirements.

Nurse Staffing: Monitor the staffing methodology that was implemented in March 2013.

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 17–27, 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
- Coordination of Care – 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 2011, FY 2012, and FY 2013 through May 9, 2013, and was done in accordance with OIG SOPs 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 Sheridan VA Medical Center, Sheridan, Wyoming,* Report No. 08-02418-202, August 25, 2009).

During this review, we presented crime awareness briefings for 175 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 208 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

Mobile Flu Cart

The facility achieved an employee vaccination rate of 76 percent compared to the national average of 48 percent. This exceptional rate can be attributed in part to the implementation of a mobile flu cart, which allows nurses access to administrative areas. Employees in administrative areas may have less opportunity to go to a clinical area to receive the shot.

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.	
	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.	
NA	Appropriate processes were in place to prevent incidents of surgical items being retained in a patient following surgery.	
X	The cardiopulmonary resuscitation review policy and processes complied with requirements for reviews of episodes of care where resuscitation was attempted.	Facility policy and 12 months of ECC meeting minutes reviewed: • ECC membership did not include all required disciplines.
X	There was an EHR quality review committee, and the review process complied with selected requirements.	Twelve months of Clinical Informatics Medical Record Committee meeting minutes reviewed: • There was no evidence that the quality of entries in the EHR was reviewed.

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.	Thirty EHRs of patients who had non-VA purchased care reviewed: • Eleven results (37 percent) were not scanned into the EHRs.
NA	Use and review of blood/transfusions complied with selected requirements.	
	CLC minimum data set forms were transmitted to the data center with the required frequency.	
	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 ECC membership includes all required disciplines.

2. We recommended that processes be strengthened to ensure that the quality of entries in the EHR is reviewed.

3. We recommended that processes be strengthened to ensure that the results of non-VA purchased care 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 homeless domiciliary, inpatient mental health, acute medicine, outpatient primary care, SPS, and the CLC. Additionally, we reviewed relevant documents, conversed with key employees and managers, and reviewed all SPS employee training and competency files. 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.	
	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 were 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.	
X	The facility used an interdisciplinary approach to monitor compliance with established RME processes, and RME-related activities were reported to an executive-level committee.	Five months of RME Management Committee minutes and 6 months of MEB minutes reviewed: • Minutes did not include results of compliance with RME SOPs.
NA	The facility had policies/procedures/guidelines for immediate use (flash) sterilization and monitored it.	
X	Employees received required RME training and competency assessment.	• For two SPS employees, documentation of initial RME training or annual competency assessments was missing.
NA	Operating room employees who performed immediate use (flash) sterilization received training and competency assessment.	
X	RME SOPs were consistent with manufacturers' instructions, procedures were located where reprocessing occurs, and sterilization was performed as required.	RME SOPs, manufacturers' instructions, and 1 day of sterilization logs for 2 RME items reviewed: • Manufacturers' instructions were not available for one RME item. • The sterilization temperature recorded on the log exceeded manufacturer instructions for one of the items reprocessed.
	Selected infection prevention/environmental safety requirements were met.	
X	Selected requirements for SPS decontamination and sterile storage areas were met.	• Sterile storage area temperature and humidity levels were not consistently monitored.
	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.	

Recommendations

4. We recommended that processes be strengthened to ensure that results of compliance with RME SOPs are reported to the RME Management Committee and the MEB.

5. We recommended that processes be strengthened to ensure that SPS employees responsible for reprocessing activities receive initial RME training and annual competency assessments.

6. We recommended that processes be strengthened to ensure that manufacturers' instructions are available for all RME items, that RME is reprocessed at the specified temperature, and that compliance be monitored.

7. We recommended that processes be strengthened to ensure that SPS sterile storage area temperature and humidity levels are consistently monitored and maintained within acceptable levels.

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: • Facility policy did not include the requirement that CS inspectors receive annual updates regarding problematic issues identified through external survey findings and other quality control measures. Consequently, CS inspectors did not receive these annual updates.
	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.	• Instructions for inspecting automated dispensing machines had not been developed.
X	Monthly CS inspection findings summaries and quarterly trend reports were provided to the facility Director.	Summary of CS inspection findings for past 6 months and quarterly trend reports for past 4 quarters reviewed: • One monthly findings summary was not provided to the facility Director. • Quarterly trend reports did not clearly summarize discrepancies and problematic trends nor did they identify potential areas for improvement.
	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.	
X	CS inspectors were appointed in writing, completed required certification and training, and were free from conflicts of interest.	Appointments, certifications, and training records reviewed: • Eight CS inspectors' appointments did not state the end date of their term nor that their term was not to exceed 3 years.

NC	Areas Reviewed (continued)	Findings
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: • The January 2013 inspections were not conducted in any of the 10 areas. • Sufficient documentation was not maintained to validate that all required monthly inspection components were completed.
X	Pharmacy CS inspections were conducted in accordance with VHA requirements and included all required elements.	Documentation of pharmacy CS inspections during the past 6 months reviewed: • The January 2013 pharmacy inspection was not conducted. • Sufficient documentation was not maintained to validate that all required pharmacy monthly inspection components were completed.
	The facility complied with any additional elements required by VHA or local policy.	

Recommendations

8. We recommended that facility policy be amended to include the requirement that CS inspectors receive annual updates regarding problematic issues identified through external survey findings and other quality control measures and that processes be strengthened to ensure that CS inspectors receive annual updates.

9. We recommended that the facility develop instructions for inspections of automated dispensing machines and that processes be strengthened to ensure that monthly findings summaries are provided to the facility Director and that quarterly trend reports clearly summarize discrepancies and problematic trends and identify potential areas for improvement.

10. We recommended that processes be strengthened to ensure that CS inspectors' appointments state the end date of their term and that CS inspectors' terms do not exceed 3 years.

11. We recommended that processes be strengthened to ensure that monthly inspections of all pharmacy and non-pharmacy areas with CS are conducted in accordance with VHA requirements and include all required elements 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 10 employee training records (5 HPC staff records and 5 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.
	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 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.	
X	The PCCT responded to consults within the required timeframe and tracked consults that had not been acted upon.	• Four consults were not acted upon within 7 days of the request and had not been tracked.
	Consult responses were attached to HPC consult requests.	
	The facility submitted the required electronic data for HPC through the VHA Support Service Center.	
	An interdisciplinary team care plan was completed for HPC inpatients within the facility's specified timeframe.	
X	HPC inpatients were assessed for pain with the frequency required by local policy.	• Two EHRs did not contain documentation of pain assessments being performed when vital signs were obtained.
	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.	

NC	Areas Reviewed (continued)	Findings
X	The facility complied with any additional elements required by local policy.	Local policy reviewed: • Pain assessments were documented in the EHR in progress notes with various titles rather than approved note titles.

Recommendations

12. We recommended that processes be strengthened to ensure that the PCCT includes a dedicated administrative support person.

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

14. We recommended that a process be established to track HPC consults that are not acted upon within 7 days of the request.

15. We recommended that processes be strengthened to ensure that HPC inpatients' pain is consistently assessed whenever vital signs are obtained and results documented in EHRs and that compliance be monitored.

16. We recommended that processes be strengthened to ensure that HPC inpatients' pain assessments are documented in EHRs using approved note titles and that compliance be monitored.

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, 10 EHRs of patients with community-acquired pressure ulcers, and 4 employee training records. 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 pressure ulcer prevention policy, and it addressed prevention for all inpatient areas and for outpatient care.	
X	The facility had an interprofessional pressure ulcer committee, and the membership included a certified wound care specialist.	• Committee membership did not include 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.	
X	Skin inspections and risk scales were performed upon transfer, change in condition, and discharge.	• Eight EHRs did not contain documentation that a skin inspection and risk scale were performed at discharge.
X	Staff were generally consistent in documenting location, stage, risk scale score, and date acquired.	• In four EHRs, staff did not consistently document the location and stage.
X	Required activities were performed for patients determined to be at risk for pressure ulcers and for patients with pressure ulcers.	• Eight EHRs did not contain consistent documentation that staff performed daily skin inspections. • None of the EHRs contained daily risk scale documentation. • Four EHRs did not contain daily monitoring for a change in condition.
	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.	• Five EHRs did not contain consistent documentation 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.	• Five EHRs did not contain evidence of wound care follow-up plans at discharge. • Five of the seven applicable EHRs did not contain evidence that patients received dressing supplies prior to 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 three of the seven applicable patients, EHRs did not contain evidence that education was provided.
X	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 had not developed staff pressure ulcer education requirements.
NA	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

17. We recommended that the interprofessional pressure ulcer committee includes a certified wound care specialist.

18. We recommended that processes be strengthened to ensure that acute care staff consistently document pressure ulcer location and stage and perform and document all required daily activities/inspections for patients with pressure ulcers and that compliance be monitored.

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

20. We recommended that processes be strengthened to ensure that acute care staff perform and document skin inspections and risk scales at discharge and that compliance be monitored.

21. We recommended that processes be strengthened to ensure that all patients discharged with pressure ulcers have wound care follow-up plans and receive dressing supplies prior to discharge and that compliance be monitored.

22. We recommended that processes be strengthened to ensure that acute care staff provide and document pressure ulcer education for patients and/or their caregivers and that compliance be monitored.

23. We recommended that the facility establish staff pressure ulcer education requirements 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 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
X	The facility completed the required steps to develop a nurse staffing methodology by the deadline.	• Expert panels were not convened until March 13, 2013.
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

24. We recommended that nursing managers monitor the staffing methodology that was implemented in March 2013.

Facility Profile (Sheridan/666) FY 2013 through March 2013[a]	
Type of Organization	Secondary
Complexity Level	3
Affiliated/Non-Affiliated	Non-affiliated
Total Medical Care Budget in Millions	$85.4
Number (through April 2013) of:	
• **Unique Patients**	10,939
• **Outpatient Visits**	71,439
• **Unique Employees**[b]	456
Type and Number of Operating Beds:	
• **Hospital**	60
• **CLC**	40
• **Mental Health**	85
Average Daily Census:	
• **Hospital**	46
• **CLC**	31
• **Mental Health**	76
Number of Community Based Outpatient Clinics	5
Location(s)/Station Number(s)	Casper/666GB Riverton/666GC Powell/666GD Gillette/666GE Rock Springs/666GF
VISN Number	19

[a] All data is for FY 2013 through March 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	53.2	60.9	57.8	51.7	57.4	48.2
VISN	62.0	64.3	51.5	53.0	51.6	52.5
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	**	12.5	13.5	**	26.7	19.0
U.S. National	15.5	11.6	12.0	19.7	24.7	18.5

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

[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 28, 2013

From: Director, Rocky Mountain Network (10N19)

Subject: **CAP Review of the Sheridan VA Healthcare System, Sheridan, WY**

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

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

1. I have reviewed the OIG Combined Assessment Program Review of the Sheridan VA Healthcare System and concur with the responses as provided by the Medical Center Director.

2. If you have any questions or would like to discuss this response, please contact me at 303-756-9279.

(original signed by:)
Ralph T. Gigliotti, FACHE

Facility Director Comments

Department of Veterans Affairs **Memorandum**

Date: June 28, 2013

From: Director, Sheridan VA Healthcare System (666/00)

Subject: **CAP Review of the Sheridan VA Healthcare System, Sheridan, WY**

To: Director, Rocky Mountain Network (10N19)

1. After reviewing this report, I concur with the identified findings.
2. The Sheridan VA Healthcare System has developed and implemented the following action plans with designated anticipated completion dates.
3. If you have any questions or would like to discuss this response, please contact me at 307-675-3675.

Debra L. Hirschman

Debra L. Hirschman

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 ECC membership includes all required disciplines.

Concur

Target date for completion: June 26, 2013 (Completed)

Facility response:

The Emergency Care Committee (ECC) membership has been revised to include representation from the following disciplines: Physician, Nursing, Respiratory Therapy, Clinical Education, Pharmacy, SPS, Patient Safety, Quality Management, CBOC designee, AFGE representative and Engineering (ad hoc). ECC minutes will reflect attendance by multidisciplinary team members.

Recommendation 2. We recommended that processes be strengthened to ensure that the quality of entries in the EHR is reviewed.

Concur

Target date for completion: August 30, 2013

Facility response:

The Clinical Informatics Medical Record Committee (CIMR) will assume responsibility for ensuring that the quality of entries in the EHR is reviewed. Medical Record reviews will occur through the following processes:

a. Point of Care reviews will be done by each nursing unit: Medical, Inpatient Psychiatric, Special Needs Unit, Community Living Center, Mental Health Residential Rehabilitation Treatment Program, and Domiciliary Care for Homeless Veterans. Data will be aggregated and reported to CIMR quarterly.
b. Inpatient and Outpatient retrospective medical record reviews will be completed by members of the CIMR committee or designees. Data will be aggregated and reported to CIMR quarterly.

Recommendation 3. We recommended that processes be strengthened to ensure that the results of non-VA purchased care are consistently scanned into EHRs.

Concur

Target date for completion: September 30, 2013

Facility response:

In conjunction with VISN 19's Network Authorization Office, the Sheridan VA Healthcare System has identified a strengthened process to ensure that unauthorized non-VA purchased care results will be scanned into the electronic health record. Compliance will be monitored quarterly and reported to the Clinical Informatics Medical Record Committee. Any barriers to success will be identified and adjustments to the process will be made.

Recommendation 4. We recommended that processes be strengthened to ensure that results of compliance with RME SOPs are reported to the RME Management Committee and the MEB.

Concur

Target date for completion: September 30, 2013

Facility response:

Standard operating procedures for Reusable Medical Equipment (RME) are in the process of being updated and staff members who use and clean RME will be educated on updates. Compliance with RME standard operating procedures will be reported at every RME Management Committee meeting and quarterly to the Medical Executive Board (MEB).

Recommendation 5. We recommended that processes be strengthened to ensure that SPS employees responsible for reprocessing activities receive initial RME training and annual competency assessments.

Concur

Target date for completion: June 26, 2013 (Completed)

Facility response:

Employees currently responsible for reprocessing activities received competency assessments completed by June 26, 2013. Assessments will occur annually in March. Compliance will be reported to the RME Management Committee.

Recommendation 6. We recommended that processes be strengthened to ensure that manufacturers' instructions are available for all RME items, that RME is reprocessed at the specified temperature, and that compliance be monitored.

Concur

Target date for completion: September 30, 2013

Facility response:

Use of the oneSOURCE electronic database is in place to provide immediate access to manufacturers' instructions for use documents.

Reprocessing of one item was found to fall outside the manufacturer's recommendation. The temperature was to be maintained between 273 and 275 degrees for ten minutes during sterilization; however the autoclave temperature increased to 276.8 degrees for one minute of the ten minute cycle. Due to the age of the current equipment, a new sterilizer is being installed with the intent to increase accuracy and maintain manufacturers' reprocessing requirements.

Compliance with RME manufacturers' instructions for use and RME reprocessing will be reported at every RME Management Committee meeting and quarterly to the Medical Executive Board.

Recommendation 7. We recommended that processes be strengthened to ensure that SPS sterile storage area temperature and humidity levels are consistently monitored and maintained within acceptable levels.

Concur

Target date for completion: September 30, 2013

Facility response:

The Checkpoint® monitoring system is used for continuous tracking of temperature and humidity levels in the SPS sterile storage areas. History logs show that temperature and humidity levels have been maintained according to standard, but they were not being actively monitored. The Checkpoint® software will be installed on the SPS Nurse's computer and the Nurse Executive's computer to ensure that temperatures and humidity will be monitored on a continual basis. Monthly reports will show temperature and humidity ranges. Reporting will occur at every RME Management Committee meeting and quarterly to the Medical Executive Board.

Recommendation 8. We recommended that facility policy be amended to include the requirement that CS inspectors receive annual updates regarding problematic issues

identified through external survey findings and other quality control measures and that processes be strengthened to ensure that CS inspectors receive annual updates.

Concur

Target date for completion: October 31, 2013

Facility response:

MCM 00-24 Inspection of Controlled Substances has been re-written to align it with VHA Handbook 1108.02. This MCM will be released 6/28/13 to go through the approval process and once final approval is received, it will be published. All inspectors have completed the Controlled Substance Inspection (CSI) TMS training and have attended a documented training session. The new MCM reflects the annual training requirement. Additionally, the newly appointed Controlled Substance Coordinator (CSC) and the alternate CSC have both taken the training.

The quarterly trending reports will be reviewed at the annual training with the meeting minutes reflecting this review.

Recommendation 9. We recommended that the facility develop instructions for inspections of automated dispensing machines and that processes be strengthened to ensure that monthly findings summaries are provided to the facility Director and that quarterly trend reports clearly summarize discrepancies and problematic trends and identify potential areas for improvement.

Concur

Target date for completion: September 30, 2013

Facility response:

Pharmacy has developed screen shots of the proper operation of the McKesson which have been distributed to all inspectors. An instruction binder is being created and will be available to all inspectors for use during inspections. The newly appointed CSC has created a process for tracking and submitting monthly summary memo and action plans. The Director signs the memo and action plans, which are then returned to the CSC to be kept in accordance with VHA Handbook 1108.02. Quarterly trending reports have been developed and will be submitted to the facility Director, pharmacy and inspectors. Reports will include discrepancies, problematic trends, areas for improvement, and identified actions.

Trending reports to include problematic issues identified through external survey and local findings have been developed and will be submitted to the facility Director, pharmacy, and inspectors on a quarterly basis. Monitoring will occur for 2 quarters to ensure reports are being submitted and signed by the Director.

Recommendation 10. We recommended that processes be strengthened to ensure that CS inspectors' appointments state the end date of their term and that CS inspectors' terms do not exceed 3 years.

Concur

Target date for completion: June 21, 2013 (Completed)

Facility response:

The new appointment letter has terminology regarding the three year term limit and also the term end date. Appointment terms will be monitored by the CSC.

Recommendation 11. We recommended that processes be strengthened to ensure that monthly inspections of all pharmacy and non-pharmacy areas with CS are conducted in accordance with VHA requirements and include all required elements and that compliance be monitored.

Concur

Target date for completion: July 30, 2013

Facility response:

The facility has added inspectors and developed a one year reoccurring inspection calendar which is included in the appointment letter. The CSC has also developed a notification process to ensure random inspections are completed timely each month. The CSC will communicate with the inspecting team after the inspection to ensure the inspection worksheet, the memo and all other pertinent paperwork is submitted and ready to be sent to the Director for review and signature. The CSC and alternate CSC are currently working to streamline the inspection worksheet and ensure all required elements are included. The CSI process will be monitored for compliance indefinitely and reported quarterly to the Quality Oversight Board.

Recommendation 12. We recommended that processes be strengthened to ensure that the PCCT includes a dedicated administrative support person.

Concur

Target date for completion: May 18, 2013 (Completed)

Facility response:

Mapping was updated to reflect the dedicated administrative support person at 0.25 FTEE for the Hospice and Palliative Care Team.

Recommendation 13. We recommended that processes be strengthened to ensure that all 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: August 30, 2013

Facility response:

Staff members who care for Veterans at end of life were assigned training in TMS called "Dying Well" provided by Swank Healthcare. Training compliance will be monitored in TMS until 100% completion is attained.

Recommendation 14. We recommended that a process be established to track HPC consults that are not acted upon within 7 days of the request.

Concur

Target date for completion: June 17, 2013 (Completed)

Facility response:

The Access database created to track open consults and patients receiving hospice and palliative care services was updated to aid the team with tracking open consults and the ability to target those open greater than seven days. This is being maintained by the administrative support for the Hospice and Palliative Care Team.

Recommendation 15. We recommended that processes be strengthened to ensure that HPC inpatients' pain is consistently assessed whenever vital signs are obtained and results documented in EHRs and that compliance be monitored.

Concur

Target date for completion: October 31, 2013

Facility response:

In accordance with VHA Directive 2009-053, Pain Management, pain will continue to be assessed as the "5th Vital Sign." The acute care Medical Unit and the Community Living Center (where the patients/residents receiving hospice and palliative care are located) have implemented process changes to ensure pain is assessed whenever vital signs are obtained for HPC patients. Documentation of pain assessment in conjunction with vital signs for HPC patients will be monitored and reported monthly to the Nursing Executive Board until 90% compliance has been maintained for three months.

Recommendation 16. We recommended that processes be strengthened to ensure that HPC inpatients' pain assessments are documented in EHRs using approved note titles and that compliance be monitored.

Concur

Target date for completion: October 31, 2013

Facility response:

Updates to MCM 11-23 Pain Management and the associated Nursing Standard of Care are being completed to ensure clarity for staff regarding requirements for consistent documentation of pain assessments. The preferred title to use will be the pain evaluation note. Education of nursing staff will occur and monitoring of pain assessment documentation for HPC patients will be reported monthly to the Nursing Executive Board until 90% compliance has been maintained for three months.

Recommendation 17. We recommended that the interprofessional pressure ulcer committee includes a certified wound care specialist.

Concur

Target date for completion: June 24, 2013 (Completed)

Facility response:

The Wound Committee chairperson, who is a Nurse Practitioner and actively manages wounds, successfully completed the Certified Wound Specialist examination on June 24, 2013.

Recommendation 18. We recommended that processes be strengthened to ensure that acute care staff consistently document pressure ulcer location and stage and perform and document all required daily activities/inspections for patients with pressure ulcers and that compliance be monitored.

Concur

Target date for completion: October 31, 2013

Facility response:

MCM 11-37 Pressure Ulcers Management and Prevention Program will be revised to align with VHA Handbook 1180.02 Prevention of Pressure Ulcers. A training video was created to educate staff on skin inspection and assessment including documentation of pressure ulcer location and stage, pressure ulcer risk scale, and additional documentation requirements noted within the Handbook. Compliance will be monitored through monthly documentation audits conducted by acute care nurse managers. Data

will be reported to the Nursing Executive Board and to the Wound Team. Meeting minutes will reflect this documentation for four consecutive months.

Recommendation 19. 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:

Acute care staff will document recommended pressure ulcer interventions in the skin assessment notes. Compliance will be monitored through monthly documentation audits conducted by acute care nurse managers. Data will be reported to the Nursing Executive Board and to the Wound Team. Meeting minutes will reflect this documentation for four consecutive months.

Recommendation 20. We recommended that processes be strengthened to ensure that acute care staff perform and document skin inspections and risk scales at discharge and that compliance be monitored.

Concur

Target date for completion: October 31, 2013

Facility response:

Staff education regarding the training video and revision of MCM 11-37 will include skin inspection, assessment of risk scales, and documentation requirements. Acute care nursing staff will document skin inspection and risk scales at discharge and nurse managers will conduct monthly documentation audits to determine compliance. Data will be reported to the Nursing Executive Board and to the Wound Team. Meeting minutes will reflect this documentation for four consecutive months.

Recommendation 21. We recommended that processes be strengthened to ensure that all patients discharged with pressure ulcers have wound care follow-up plans and receive dressing supplies prior to discharge and that compliance be monitored.

Concur

Target date for completion: October 31, 2013

Facility response:

All patients discharged with pressure ulcers will have wound care follow-up plans and take-home dressings supplies documented on the nursing discharge note. Compliance

will be monitored through monthly documentation audits conducted by nurse managers. Meeting minutes will reflect this documentation for four consecutive months.

Recommendation 22. We recommended that processes be strengthened to ensure that acute care staff provide and document pressure ulcer education for patients and/or their caregivers and that compliance be monitored.

Concur

Target date for completion: October 31, 2013

Facility response:

The patient education template will be revised to include pressure ulcer education for patients and/or caregivers. Acute care staff will be educated on template revision and pressure ulcer education requirements for patients with pressure ulcers and/or their caregivers. Compliance will be monitored through monthly documentation audits conducted by acute care nurse managers. Meeting minutes will reflect this documentation for four consecutive months.

Recommendation 23. We recommended that the facility establish staff pressure ulcer education requirements and that compliance be monitored.

Concur

Target date for completion: October 31, 2013

Facility response:

Annual pressure ulcer education requirements have been established for all nursing staff and Wound Team members. Staff education compliance will be monitored by nurse managers and the Wound Team chairperson until 90% completion has been attained.

Recommendation 24. We recommended that nursing managers monitor the staffing methodology that was implemented in March 2013.

Concur

Target date for completion: August 30, 2013

Facility response:

Unit-based Nursing Hours per Patient Day (NHPPD) are monitored daily by each Nurse Manager. Monthly NHPPD reports containing analysis, trending, and action plans will be provided to the Nursing Executive Board to include overall NHPPD, required and actual; analysis and management of staffing plan; and documentation of adverse events.

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Endnotes

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