Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 13-01972-284

Combined Assessment Program Review of the Charlie Norwood VA Medical Center Augusta, Georgia

August 19, 2013

Washington, DC 20420

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

Glossary

CAP	Combined Assessment Program
CLC	community living center
CS	controlled substances
EHR	electronic health record
EOC	environment of care
facility	Charlie Norwood VA Medical Center
FPPE	Focused Professional Practice Evaluation
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
PU	pressure ulcer
QM	quality management
RME	reusable medical equipment
SPS	Sterile Processing Service
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

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Executive Summary

Review Purpose: The purpose of the review was to evaluate selected health care facility operations, focusing on patient care quality and the environment of care, and to provide crime awareness briefings. We conducted the review the week of June 3, 2013.

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

- Coordination of Care – Hospice and Palliative Care
- Nurse Staffing

The facility's reported accomplishments were a community living center restorative gymnasium and orthopedic joint replacement services.

Recommendations: We made recommendations in the following four activities:

Quality Management: Consistently complete Focused Professional Practice Evaluations for newly hired licensed independent practitioners. Include in code reviews screening for clinical issues prior to codes that may have contributed to the occurrence of the codes. Consistently scan results of non-VA purchased diagnostic tests into electronic health records. Ensure clinicians perform and document patient assessments following blood product transfusions.

Environment of Care: Ensure Infection Prevention/Control Committee minutes reflect follow-up on actions that were implemented to address identified problems. Require that patient care area ventilation system outlets, public restrooms, and nourishment refrigerators are clean. Ensure restrooms designated for female patients in the women's health clinic have door locks. Maintain Sterile Processing Service sterile storage area humidity levels within acceptable levels.

Medication Management – Controlled Substances Inspections: Inspect all required non-pharmacy areas with controlled substances. Ensure inspectors verify five hard copy prescription orders for all non-pharmacy areas.

Pressure Ulcer Prevention and Management: Provide and document pressure ulcer education for patients at risk for and with pressure ulcers and/or their caregivers. Ensure equipment used for medication administration is routinely inspected and repaired or removed from service. Secure prescription medications at all times.

Comments

The Veterans Integrated Service Network Director and Interim Facility Director agreed with the Combined Assessment Program review findings and recommendations and provided acceptable improvement plans. (See Appendixes C and D, pages 16–22, 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

The scope of the CAP review is limited. Serious issues that come to our attention that are outside the scope will be considered for further review separate from the CAP process and may be referred accordingly.

For this review, we examined selected clinical and administrative activities to determine whether facility performance met requirements related to patient care quality and the EOC. In performing the review, we inspected selected areas, conversed with managers and employees, and reviewed clinical and administrative records. The review covered the following six activities:

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

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

The review covered facility operations for FY 2012 and FY 2013 through June 6, 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*

Charlie Norwood VA Medical Center, Augusta, Georgia, Report No. 09-03298-80, February 2, 2010).

During this review, we presented crime awareness briefings for 635 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 665 responded. We shared summarized results with facility managers.

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

Reported Accomplishments

CLC Restorative Gymnasium

Through interdisciplinary collaboration, a restorative gymnasium was opened in January 2013 to provide a private space for CLC residents to maintain or attain their functional abilities. The gymnasium is open from 8:00 a.m. to 3:00 p.m., and residents have scheduled appointments and snacks afterwards. Previously, CLC residents received restorative care only at their bedside and often refused. Since the gymnasium opened, the restorative care refusal rate has decreased from 60 percent to 10 percent. Additionally, employees have noted that through gymnasium participation, residents have formed friendships with other residents and have bonded with restorative care staff.

Orthopedic Joint Replacement Services

In November 2012, $2.9 million in incentive funding for orthopedic joint replacement services was awarded to the facility and other members of the Georgia Federal Healthcare Executive Council. Other council participants include the Dwight David Eisenhower Army Medical Center and the Carl Vinson VA Medical Center. The purpose of this funding is to provide joint replacement services to the veteran population of Georgia while maximizing the utilization of orthopedic surgical services and operating room facilities at Dwight David Eisenhower Army Medical Center and the post-operative rehabilitation services at both the Carl Vinson VA Medical Center and the facility. As of April 2013, nine veterans have benefited from this partnership.

Results and Recommendations

QM

The purpose of this review was to determine whether facility senior managers actively supported and appropriately responded to QM efforts and whether the facility complied with selected requirements within its QM program.[1]

We conversed with senior managers and key QM employees, and we evaluated meeting minutes, EHRs, and other relevant documents. The table below shows the areas reviewed for this topic. The areas marked as NC needed improvement. Any items that did not apply to this facility are marked NA.

NC	Areas Reviewed	Findings
	There was a senior-level committee/group responsible for QM/performance improvement, and it included the required members.	
	There was evidence that Inpatient Evaluation Center data was discussed by senior managers.	
	Corrective actions from the protected peer review process were reported to the Peer Review Committee.	
X	FPPEs for newly hired licensed independent practitioners complied with selected requirements.	Fifteen profiles reviewed: • Of 14 FPPEs initiated, 2 were not completed.
	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.	
X	The cardiopulmonary resuscitation review policy and processes complied with requirements for reviews of episodes of care where resuscitation was attempted.	• There was no evidence that code reviews included screening for clinical issues prior to codes that may have contributed to the occurrence of the codes.
	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
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 diagnostic tests reviewed: • Twenty-three test results (77 percent) were not scanned into the EHRs.
X	Use and review of blood/transfusions complied with selected requirements.	Twenty-seven EHRs of patients who received blood products reviewed: • Six EHRs contained no documentation that the outcome was assessed.
	CLC minimum data set forms were transmitted to the data center with the required frequency.	
	Overall, if significant issues were identified, actions were taken and evaluated for effectiveness.	
	There was evidence at the senior leadership level that QM, patient safety, and systems redesign were integrated.	
	Overall, there was evidence that senior managers were involved in performance improvement over the past 12 months.	
	Overall, the facility had a comprehensive, effective QM/performance improvement program over the past 12 months.	
	The facility complied with any additional elements required by VHA or local policy.	

Recommendations

1. We recommended that processes be strengthened to ensure that FPPEs for newly hired licensed independent practitioners are consistently completed.

2. We recommended that processes be strengthened to ensure that code reviews include screening for clinical issues prior to codes that may have contributed to the occurrence of the codes.

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

4. We recommended that processes be strengthened to ensure that clinicians perform and document patient assessments following blood product transfusions.

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 15 areas. At the downtown division, we inspected the emergency department; the 4A (surgical), 5D (medical), critical care, spinal cord injury, and hemodialysis inpatient units; the 4D (primary care) and gastrointestinal clinics; and SPS. At the uptown division, we inspected the CLC (1C, 2A, and 2B) and acute MH units and the women's health and dental clinics. Additionally, we reviewed relevant documents, conversed with key employees and managers, and reviewed 29 employee training and competency files (9 hemodialysis, 10 operating room, and 10 SPS). The table below shows the areas reviewed for this topic. The areas marked as NC needed improvement. Any items that did not apply to this facility are marked NA.

NC	Areas Reviewed for General EOC	Findings
	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.	
X	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.	Six months of Infection Prevention/Control Committee meeting minutes reviewed: • Minutes did not reflect follow-up on actions that were implemented to address identified problems.
	Fire safety requirements were met.	
X	Environmental safety requirements were met.	• Nine of 12 patient care areas did not have clean ventilation system outlets. • Two public restrooms were in need of cleaning. • Three of nine patient nourishment refrigerators were in need of cleaning.
	Infection prevention requirements were met.	
	Medication safety and security requirements were met.	
	Sensitive patient information was protected, and patient privacy requirements were met.	
X	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.	VHA policy reviewed: • Women's health clinic restrooms had two doors that opened into adjoining examination rooms, but the doors did not have locks.

NC	Areas Reviewed for Hemodialysis	Findings
	The facility had policy detailing the cleaning and disinfection of hemodialysis equipment and environmental surfaces and the management of infection prevention precautions patients.	
	Monthly biological water and dialysate testing were conducted and included required components, and identified problems were corrected.	
	Employees received training on bloodborne pathogens.	
	Employee hand hygiene monitoring was conducted, and any needed corrective actions were implemented.	
	Selected EOC/infection prevention/safety requirements were met.	
	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.	
	Areas Reviewed for SPS/RME	
	The facility had policies/procedures/guidelines for cleaning, disinfecting, and sterilizing RME.	
	The facility used an interdisciplinary approach to monitor compliance with established RME processes, and RME-related activities were reported to an executive-level committee.	
	The facility had policies/procedures/guidelines for immediate use (flash) sterilization and monitored it.	
	Employees received required RME training and competency assessment.	
	Operating room employees who performed immediate use (flash) sterilization received training and competency assessment.	
	RME standard operating procedures were consistent with manufacturers' instructions, procedures were located where reprocessing occurs, and sterilization was performed as required.	
	Selected infection prevention/environmental safety requirements were met.	
X	Selected requirements for SPS decontamination and sterile storage areas were met.	• Sterile storage area humidity levels were out of range for 5 consecutive weeks.
	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.	

Recommendations

5. We recommended that processes be strengthened to ensure that Infection Prevention/Control Committee minutes reflect follow-up on actions that were implemented to address identified problems.

6. We recommended that processes be strengthened to ensure that patient care area ventilation system outlets, public restrooms, and nourishment refrigerators are clean and that compliance be monitored.

7. We recommended that processes be strengthened to ensure that restrooms designated for female patients in the women's health clinic have door locks.

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

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, the alternate CS Coordinator, 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 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.	
	VA police conducted annual physical security surveys of the pharmacy/pharmacies, and any identified deficiencies were corrected.	
	Instructions for inspecting automated dispensing machines were documented, included all required elements, and were followed.	
	Monthly CS inspection findings summaries and quarterly trend reports were provided to the facility Director.	
	CS Coordinator position description(s) or functional statement(s) included duties, and CS Coordinator(s) completed required certification and were free from conflicts of interest.	
	CS inspectors were appointed in writing, completed required certification and training, and were free from conflicts of interest.	
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: • Four required areas were not inspected for 2 consecutive months. • Inspectors did not verify 5 hard copy prescription orders for 4 months in 3 separate non-pharmacy areas.
	Pharmacy CS inspections were conducted in accordance with VHA requirements and included all required elements.	
	The facility complied with any additional elements required by VHA or local policy.	

Recommendations

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

10. We recommended that processes be strengthened to ensure that inspectors verify five hard copy prescription orders for all non-pharmacy areas and that compliance be monitored.

Coordination of Care – HPC

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

We reviewed relevant documents, 20 EHRs of patients who had PCCT consults (including 10 HPC inpatients), and 25 employee training records (10 HPC staff records and 15 non-HPC staff records), and we conversed with key employees. The table below shows the areas reviewed for this topic. 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
	A PCCT was in place and had the dedicated staff required.	
	The PCCT actively sought patients appropriate for HPC.	
	The PCCT offered end-of-life training.	
	HPC staff and selected non-HPC staff had end-of-life training.	
	The facility had a VA liaison with community hospice programs.	
	The PCCT promoted patient choice of location for hospice care.	
	The CLC-based hospice program offered bereavement services.	
	The HPC consult contained the word “palliative” or “hospice” in the title.	
	HPC consults were submitted through the Computerized Patient Record System.	
	The PCCT responded to consults within the required timeframe and tracked consults that had not been acted upon.	
	Consult responses were attached to HPC consult requests.	
	The facility submitted the required electronic data for HPC through the VHA Support Service Center.	
	An interdisciplinary team care plan was completed for HPC inpatients within the facility’s specified timeframe.	
	HPC inpatients were assessed for pain with the frequency required by local policy.	
	HPC inpatients’ pain was managed according to the interventions included in the care plan.	
	HPC inpatients were screened for an advanced directive upon admission and according to local policy.	
	The facility complied with any additional elements required by VHA or local policy.	

PU Prevention and Management

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

We reviewed relevant documents, 26 EHRs of patients with PUs (10 patients with hospital-acquired PUs, 10 patients with community-acquired PUs, and 6 patients with PUs at the time of our onsite visit), and 10 employee training records. Additionally, we inspected three patient rooms. The table below shows the areas reviewed for this topic. The areas marked as NC needed improvement. Any items that did not apply to this facility are marked NA.

NC	Areas Reviewed	Findings
	The facility had a PU prevention policy, and it addressed prevention for all inpatient areas and for outpatient care.	
	The facility had an interprofessional PU committee, and the membership included a certified wound care specialist.	
	PU data was analyzed and reported to facility executive leadership.	
	Complete skin assessments were performed within 24 hours of acute care admissions.	
	Skin inspections and risk scales were performed upon transfer, change in condition, and discharge.	
	Staff were generally consistent in documenting location, stage, risk scale score, and date acquired.	
	Required activities were performed for patients determined to be at risk for PUs and for patients with PUs.	
	Required activities were performed for patients determined to not be at risk for PUs.	
	For patients at risk for and with PUs interprofessional treatment plans were developed, interventions were recommended, and EHR documentation reflected that interventions were provided.	
	If the patient's PU was not healed at discharge, a wound care follow-up plan was documented, and the patient was provided appropriate dressing supplies.	
X	The facility defined requirements for patient and caregiver PU education, and education on PU prevention and development was provided to those at risk for and with PUs and/or their caregivers.	Facility PU patient and caregiver education requirements reviewed: • For 7 of 17 applicable patients at risk for/with a PU, EHRs did not contain evidence that education was provided.

NC	Areas Reviewed (continued)	Findings
	The facility-defined requirements for staff PU education, and acute care staff received training on how to administer the PU risk scale, conduct the complete skin assessment, and accurately document findings.	
X	The facility complied with selected fire and environmental safety, infection prevention, and medication safety and security requirements in PU patient rooms.	Infection prevention: • A medication barcode scanner and its holder, used in multiple patient rooms, were in disrepair and held together with cloth tape, which limited effective cleaning. Medication safety and security: • In all three rooms, prescription ointments and creams were stored in an unlocked drawer.
	The facility complied with any additional elements required by VHA or local policy.	

Recommendations

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

12. We recommended that processes be strengthened to ensure that equipment used for medication administration is routinely inspected and repaired or removed from service.

13. We recommended that processes be strengthened to ensure that prescription medications are secured at all times 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 43 training files, and we conversed with key employees. Additionally, we reviewed the actual nursing hours per patient day reported by the facility for acute medical/surgical unit 5D, CLC unit 1D, and MH unit 2G for 52 randomly selected days (holidays, weekdays, and weekend days) between October 1, 2012, and March 31, 2013. The table below shows the areas reviewed for this topic. Any items that did not apply to this facility are marked NA. The facility generally met requirements. We made no recommendations.

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

Facility Profile (Augusta/509) FY 2013 through April 2013[a]	
Type of Organization	Tertiary
Complexity Level	1b-High complexity
Affiliated/Non-Affiliated	Affiliated
Total Medical Care Budget in Millions	$328.5
Number (through May 2013) of:	
• **Unique Patients**	35,738
• **Outpatient Visits**	305,562
• **Unique Employees**[b]	1,895
Type and Number of Operating Beds:	
• **Hospital**	255
• **CLC**	132
• **MH**	60
Average Daily Census:	
• **Hospital**	145
• **CLC**	88
• **MH**	38
Number of Community Based Outpatient Clinics	2
Location(s)/Station Number(s)	Athens/509GA Aiken/509GB
VISN Number	7

[a] All data is for FY 2013 through April 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	54.5	61.5	56.3	44.5	52.2	52.4
VISN	63.3	65.9	51.8	51.3	50.6	51.1
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	18.0	12.3	17.4	19.8	24.0	19.0
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: August 1, 2013

From: Director, VA Southeast Network (10N7)

Subject: **CAP Review of the Charlie Norwood VA Medical Center, Augusta, GA**

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

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

1. I have reviewed the findings and recommendations for the subject report and I support the medical center's concurrence and action plans.

2. If there are any further, questions or comments please contact Robin Hindsman, Psy.D, Quality Management Officer, VISN 7 at 678-925-5723.

(original signed by:)
Charles E. Sepich, FACHE

Interim Facility Director Comments

Department of Veterans Affairs **Memorandum**

Date: July 29, 2013

From: Interim Director, Charlie Norwood VA Medical Center, Augusta, GA (509/00)

Subject: **CAP Review of Charlie Norwood VA Medical Center, Augusta, GA**

To: Director, VA Southeast Network (10N7)

1. I have reviewed the draft report and concur with the report's recommendations.

2. Thank you for the opportunity to review the draft report. Attached is the complete corrective action plan for the report's recommendations. If you have any questions, please contact Kimberlie Denmark, RN, Chief, Quality Management Service, at 706-733-0188, extension 2447.

(original signed by:)
Michelle Cox-Henley, RN, MSN

Attachment

Comments to OIG's Report

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

OIG Recommendations

Recommendation 1. We recommended that processes be strengthened to ensure that FPPEs for newly hired licensed independent practitioners are consistently completed.

Concur

Target date for completion: December 15, 2013

Facility response: To ensure the FPPEs are consistently completed, the Medical Staff Office dedicated a coordinator to track and manage the FPPE program. The coordinator has enhanced the process by the development of an Excel database to track Providers scheduled for FPPE process. The FPPE's are scheduled for completion within 90 days, unless the Professional Standards Board (PSB) approves a for 30 day extension. The FPPE's will be presented to the PSB for recommendation within 30 days of the due date of completion. Random audits will be conducted to ensure FPPE completion within the prescribed timeframes with a goal of 90% sustained compliance.

Recommendation 2. We recommended that processes be strengthened to ensure that code reviews include screening for clinical issues prior to codes that may have contributed to the occurrence of the codes.

Concur

Target date for completion: December 15, 2013

Facility response: The CPR Committee will review and revise the existing code review tool to include clinical issues prior to the code that may have contributed to the code. This information will be compiled monthly and included in the code review data presentation to the CPR Committee quarterly.

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

Concur

Target date for completion: December 15, 2013

Facility response: June 2013, the NVCC and HIMS department collaborated to develop a more responsive and effective process. The process ensured that clinically appropriate and complete results for Non-VA Care records are scanned within 72 hours

of receipt and date stamped by the scanning unit. An SOP will be developed to outline this process. Random audits will be conducted to ensure the diagnostic results are scanned and date stamped into the EHR within the 72 hour timeframe after receipt from the NVCC with a goal of 90% sustained compliance.

Recommendation 4. We recommended that processes be strengthened to ensure that clinicians perform and document patient assessments following blood product transfusions.

Concur

Target date for completion: December 15, 2013

Facility response: Medical Staff will be responsible for documenting the outcome assessment following blood transfusion in the medical record. Education and notification of required compliance will be provided to the medical staff by the Chief of Staff. The Associate Chief of Staff for Education/Affiliation is responsible for ensuring the education of the medical staff on the facility's required documentation following blood product administration by the licensed independent practitioners is completed and maintained at minimum of is 90%. Random audits will be conducted to ensure the outcomes assessments of blood product administration are completed and documented with a goal of 90% sustained compliance.

Recommendation 5. We recommended that processes be strengthened to ensure that Infection Prevention/Control Committee minutes reflect follow-up on actions that were implemented to address identified problems.

Concur

Target date for completion: December 15, 2013

Facility response: To ensure documentation reveals the analysis of problems, plans for resolution, interventions taken and follow-up evaluations, the template for the Infection Prevention/Control Committee minutes has been modified to reflect these components for ongoing follow through of identified issues. Review of the committee's prior minutes will be conducted when developing the next meeting's agenda for old business items. The new format was implemented in May 2013. The Infection Control Chairperson will complete a review of the past 6 months' minutes to ensure closure for all items requiring follow-up have been addressed or remain as an open agenda item for follow action. Audit for completion of follow through and/or follow up will be conducted to ensure compliance is sustained over the next quarter.

Recommendation 6. We recommended that processes be strengthened to ensure that patient care area ventilation system outlets, public restrooms, and nourishment refrigerators are clean and that compliance be monitored.

Concur

Target date for completion: December 15, 2013

Facility response: During the survey process, the Environmental Management Services (EMS) Leadership conducted a full inspection of all noted problem areas, corrected all identified issues and verified follow-up cleaning was completed. To confirm this cleanliness is maintained, the existing auditing tool used for biweekly rounds was reviewed and confirmed the inclusion of these areas/items. EMS is in progress of reinforcing their training for staff regarding proper cleaning of these areas. Education will be provided and tracked with a completion of 90% to the appropriate EMS staff. Ongoing compliance is maintained by entering the audit tool results in the existing EMS database review program for sustained compliance of 90% for the identified areas.

Work order# AD130725-003 was generated to the Downtown Division HVAC Shop to systematically replace the ventilation system outlets, due to the inability to be properly cleaned.

Recommendation 7. We recommended that processes be strengthened to ensure that restrooms designated for female patients in the women's health clinic have door locks.

Concur

Target date for completion: December 15, 2013

Facility response: Appropriate locking devices for the women's restroom have been selected and approved. The order has been submitted and locks will be installed upon receipt.

Recommendation 8. We recommended that processes be strengthened to ensure that SPS sterile storage area humidity levels are maintained within acceptable levels and that compliance be monitored.

Concur

Target date for completion: December 15, 2013

Facility response: Existing humidity levels will continue to be monitored by the Metysis System every 10 minutes and any issues will be addressed within the capabilities of the existing building service equipment. When the humidity is outside the acceptable range, engineering will repair, adjust or modify the equipment to bring the humidity to an acceptable range and the action will be tracked to ensure resolution. MCP will be reviewed and revised to address range outliers and the notification process. A

complete renovation of the existing space for SPS operations is planned and construction is to begin in August 2013.

Recommendation 9. We recommended that processes be strengthened to ensure that all required non-pharmacy areas with CS are inspected and that compliance be monitored.

Concur

Target date for completion: December 15, 2013

Facility response: Monthly inspections are scheduled to provide a strict timeframe for inspection completion. Education has also been provided to inspectors concerning assigned inspection guidelines, timeframes, and inspector responsibilities if unable to perform a scheduled inspection. An SOP will be developed outlining these requirements, timeframes and guidelines. Audit will be conducted to ensure that all-required non-pharmacy areas with CS are inspected and tracked for continued monitoring for a target of 100% for all required non-pharmacy areas for sustained compliance for the next quarter, then no greater than one missed inspection per year.

Recommendation 10. We recommended that processes be strengthened to ensure that inspectors verify five hard copy prescription orders for all non-pharmacy areas and that compliance will be monitored.

Concur

Target date for completion: December 15, 2013

Facility response: The five hard copy prescription verification process for non-pharmacy area is completed as part of a consolidated review for uptown and downtown areas. In the past, the identified areas were not part of the existing review. The review forms have been revised to capture all inspection areas. Random audits will be conducted to ensure a target of 90% sustained compliance.

Recommendation 11. We recommended that processes be strengthened to ensure that acute care staff provide and document PU education for patients at risk for and with PUs and/or their caregivers and that compliance be monitored.

Concur

Target date for completion: December 15, 2013

Facility response: To ensure that staff is documenting the education provided to patients at risk for PU and their caregivers, a program outlining the method of documenting this in the EHR will be provided by the wound care nurse. The unit skin care champion or designee will be responsible for auditing, tracking and trending results for compliance in the existing performance improvement excel database. Random audits will be conducted to maintain a target of 90% sustained compliance.

Recommendation 12. We recommended that processes be strengthened to ensure that equipment used for medication administration is routinely inspected and repaired or removed from service.

Concur

Target date for completion: December 15, 2013

Facility response: To address this problem, a systematic program for replacement of older scanners has been launched and over 18 new scanners have been replaced. In addition, a review of the policy for handling damaged equipment will be completed and revisions made as appropriate. The process will include, a replacement cart, if it is necessary to remove a BCMA cart from use. A task force has examined the usage and inspection concerns. A random audit for proper identification of service needs and completion/follow-up has been completed with a target of 90% sustained compliance.

Recommendation 13. We recommended that processes be strengthened to ensure that prescription medications are secured at all times and that compliance be monitored.

Concur

Target date for completion: December 15, 2013

Facility response: Medications will not be stored in patient rooms but kept in the BCMA cart or in the medication room to ensure they are secure. Ongoing audits of patient's rooms and related areas will be conducted to ensure that medications are secure. Compliance will be tracked and trended and the outcome data will be entered in the excel database for a target of 90% sustained compliance.

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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.
- VHA Handbook 1330.01, *Health Care Services for Women Veterans*, May 21, 2010.
- 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.