Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 13-01973-288

Combined Assessment Program Review of the Fargo VA Health Care System Fargo, North Dakota

August 26, 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
EHR	electronic health record
EOC	environment of care
facility	Fargo VA Health Care System
FPPE	Focused Professional Practice Evaluation
FY	fiscal year
HPC	hospice and palliative care
ICC	Infection Control Committee
LIP	licensed independent practitioner
NA	not applicable
NC	noncompliant
OIG	Office of Inspector General
PCCT	Palliative Care Consult Team
QM	quality management
RME	reusable medical equipment
SPS	Sterile Processing Service
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

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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 10, 2013.

Review Results: The review covered seven activities. We made no recommendations in the following three activities:

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

The facility's reported accomplishment was a health video mailing system of 16 different commercially produced videos that have reinforced interventions for improved care for rural veterans.

Recommendations: We made recommendations in the following four activities:

Quality Management: Consistently initiate Focused Professional Practice Evaluations for newly hired licensed independent practitioners. Consistently scan the results of non-VA purchased care during which diagnostic tests are performed into electronic health records.

Medication Management – Controlled Substances Inspections: Develop instructions for inspections of automated dispensing machines. Require all inspectors to complete the Controlled Substance Drug-Diversion Inspection Certification prior to beginning inspections and annually. Ensure all inspectors receive annual updates and refresher training. Conduct monthly inspections of all pharmacy and non-pharmacy areas with controlled substances in accordance with Veterans Health Administration requirements. Document inspector competencies. Ensure inspectors date and initial inspection documents at the time of inspection.

Pressure Ulcer Prevention and Management: Perform and document a patient skin inspection and risk scale at discharge. Accurately document location, stage, risk scale score, and the date the pressure ulcer was acquired for all patients with pressure ulcers. Ensure all patients discharged with pressure ulcers have wound care follow-up plans.

Construction Safety: Include time of inspections, type of corrective action for identified deficiencies, and date and time of corrective actions in documentation of construction site inspections. Ensure infection surveillance activities related to construction projects are conducted and documented in Infection Control Committee minutes.

Comments

The Veterans Integrated Service Network Director and Acting Facility Director agreed with the Combined Assessment Program Review findings and recommendations and provided acceptable improvement plans. (See Appendixes C and D, pages 18–26, for the full text of the Directors' comments.) We will follow up on the planned actions until they are completed.

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

Objectives and Scope

Objectives

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

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

Scope

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

- QM
- EOC
- Medication Management – CS Inspections
- Coordination of Care – HPC
- Pressure Ulcer Prevention and Management
- Nurse Staffing
- Construction Safety

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

The review covered facility operations for FY 2012 and FY 2013 through June 13, 2013, and was done in accordance with OIG standard operating procedures for CAP reviews. We also asked the facility to provide the status on the recommendations we made in our previous CAP report (*Combined Assessment Program Review of the Fargo VA Medical Center, Fargo, North Dakota,* Report No. 09-03745-250, September 20, 2010).

During this review, we presented crime awareness briefings for 170 employees. These briefings covered procedures for reporting suspected criminal activity to the OIG and included case-specific examples illustrating procurement fraud, conflicts of interest, and bribery.

Additionally, we surveyed employees regarding patient safety and quality of care at the facility. An electronic survey was made available to all facility employees, and 316 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

Health Video Mailing System

The Vet Flix health video mailing system uses commercially produced videos of 16 topics to reinforce interventions for rural veterans. The videos explain diet, exercise, and other information and provide one more tool for improved veteran care. As of June 17, 2013, 81 videos had been mailed. Of those returned, 84 percent were accompanied by comment cards, all of which were positive.

Results and Recommendations

QM

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

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

NC	Areas Reviewed	Findings
	There was a senior-level committee/group responsible for QM/performance improvement, and it included the required members.	
	There was evidence that Inpatient Evaluation Center data was discussed by senior managers.	
	Corrective actions from the protected peer review process were reported to the Peer Review Committee.	
X	FPPEs for newly hired LIPs complied with selected requirements.	Eleven profiles reviewed: • Four FPPEs were not initiated.
	Local policy for the use of observation beds complied with selected requirements.	
	Data regarding appropriateness of observation bed use was gathered, and conversions to acute admissions were less than 30 percent, or the facility had reassessed observation criteria and proper utilization.	
	Staff performed continuing stay reviews on at least 75 percent of patients in acute beds.	
	Appropriate processes were in place to prevent incidents of surgical items being retained in a patient following surgery.	
	The cardiopulmonary resuscitation review policy and processes complied with requirements for reviews of episodes of care where resuscitation was attempted.	
	There was an EHR quality review committee, and the review process complied with selected requirements.	
	The EHR copy and paste function was monitored.	

NC	Areas Reviewed (continued)	Findings
	Appropriate quality control processes were in place for non-VA care documents, and the documents were scanned into EHRs.	Twenty-four EHRs of patients who had non-VA purchased diagnostic tests reviewed: • Five episodes of care were not scanned into the EHRs.
	Use and review of blood/transfusions complied with selected requirements.	
	CLC minimum data set forms were transmitted to the data center with the required frequency.	
	Overall, if significant issues were identified, actions were taken and evaluated for effectiveness.	
	There was evidence at the senior leadership level that QM, patient safety, and systems redesign were integrated.	
	Overall, there was evidence that senior managers were involved in performance improvement over the past 12 months.	
	Overall, the facility had a comprehensive, effective QM/performance improvement program over the past 12 months.	
	The facility complied with any additional elements required by VHA or local policy.	

Recommendations

1. We recommended that processes be strengthened to ensure that FPPEs for newly hired LIPs are consistently initiated.

2. We recommended that processes be strengthened to ensure that the results of non-VA purchased care during which diagnostic tests are performed 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 inpatient mental health, the general medical/surgery unit, the intensive care unit, the emergency department, the CLC, outpatient ambulatory care, radiology, hemodialysis, and SPS. Additionally, we reviewed relevant documents, conversed with key employees and managers, and reviewed 26 employee training and competency files (6 hemodialysis, 10 operating room, and 10 SPS). The table below shows the areas reviewed for this topic. Any items that did not apply to this facility are marked NA. The facility generally met requirements. We made no recommendations.

NC	Areas Reviewed for General EOC	Findings
	EOC Committee minutes reflected sufficient detail regarding identified deficiencies, corrective actions taken, and tracking of corrective actions to closure.	
	An infection prevention risk assessment was conducted, and actions were implemented to address high-risk areas.	
	Infection Prevention/Control Committee minutes documented discussion of identified problem areas and follow-up on implemented actions and included analysis of surveillance activities and data.	
	Fire safety requirements were met.	
	Environmental safety requirements were met.	
	Infection prevention requirements were met.	
	Medication safety and security requirements were met.	
	Sensitive patient information was protected, and patient privacy requirements were met.	
	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.	
	Areas Reviewed for Hemodialysis	
	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 was conducted and included required components, and identified problems were corrected.	

NC	Areas Reviewed for Hemodialysis (continued)	Findings
	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.	
	Selected requirements for SPS decontamination and sterile storage areas were met.	
	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.	

Medication Management – CS Inspections

The purpose of this review was to determine whether the facility complied with requirements related to CS security and inspections.[3]

We reviewed relevant documents and conversed with key employees. We also reviewed the training files of 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
	Facility policy was consistent with VHA requirements.	
	VA police conducted annual physical security surveys of the pharmacy/pharmacies, and any identified deficiencies were corrected.	
X	Instructions for inspecting automated dispensing machines were documented, included all required elements, and were followed.	• Instructions for inspecting automated dispensing machines had not been developed.
	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.	
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: • Two CS inspectors did not complete the CS Drug-Diversion Inspection Certification prior to beginning CS inspections. • Five of the seven applicable CS inspectors did not complete annual certification in accordance with local requirements. • Six of the seven applicable CS inspectors did not receive annual updates and refresher training.
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: • There was no evidence that 1 day's dispensing from the pharmacy was reconciled to each automated unit. • There was no evidence that a hard copy order for at least two randomly selected dispensing activities was verified.

NC	Areas Reviewed (continued)	Findings
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: • Verification of the number of prescription pads was not consistently included. • Seventy-two hour inventories of the main vault were not consistently performed. • Physical counts of all pharmacy drugs were not completed during the 1st month of the quarter. • Inspectors did not verify hard copy prescriptions for 10 percent of the schedule II drugs dispensed in the outpatient pharmacy. • Inspectors did not consistently verify the audit trail by comparing drugs held for destruction with the Destruction File Holding Report. • Inspectors did not consistently verify that drug destructions were completed at least quarterly. • Audit trails for destruction of 10 randomly selected drugs were not consistently verified.
X	The facility complied with any additional elements required by local policy.	Facility CS inspection policy reviewed: • The facility did not document inspector competencies, and inspectors did not date and initial inspection documents at the time of inspection.

Recommendations

3. We recommended that the facility develop instructions for inspections of automated dispensing machines and that compliance be monitored.

4. We recommended that processes be strengthened to ensure that all CS inspectors complete the CS Drug-Diversion Inspection Certification prior to beginning CS inspections and annually and that all CS inspectors receive annual updates and refresher training and that compliance be monitored.

5. We recommended that processes be strengthened to ensure that 1 day's dispensing from the pharmacy to each automated unit is consistently reconciled and that a hard copy order for at least 2 randomly selected dispensing activities is verified and that compliance be monitored.

6. We recommended that processes be strengthened to ensure that inspectors consistently verify the number of prescription pads and that 72-hour inventories of the main vault are consistently performed and that compliance be monitored.

7. We recommended that processes be strengthened to ensure that physical counts of all pharmacy drugs are completed during the 1st month of the quarter and that compliance be monitored.

8. We recommended that processes be strengthened to ensure that inspectors verify hard copy prescriptions for 10 percent of the schedule II drugs dispensed in the outpatient pharmacy and that compliance be monitored.

9. We recommended that processes be strengthened to ensure that drugs held for destruction are consistently compared with the Destruction File Holding Report, that inspectors consistently verify drug destructions are completed at least quarterly, and that inspectors ensure audit trails for destruction of 10 randomly selected drugs are consistently verified and that compliance be monitored.

10. We recommended that processes be strengthened to ensure that inspector competencies are documented and that inspectors date and initial inspection documents at the time of the inspection 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 21 employee training records (6 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.	

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, 16 EHRs of patients with pressure ulcers (5 patients with hospital-acquired pressure ulcers, 10 patients with community-acquired pressure ulcers, and 1 patient with multiple pressure ulcers at the time of our onsite visit), and 10 employee training records. Additionally, we inspected one patient room. The table below shows the areas reviewed for this topic. The areas marked as NC needed improvement. Any items that did not apply to this facility are marked NA.

NC	Areas Reviewed	Findings
	The facility had a pressure ulcer prevention policy, and it addressed prevention for all inpatient areas and for outpatient care.	
	The facility had an interprofessional pressure ulcer committee, and the membership included a certified wound care specialist.	
	Pressure ulcer data was analyzed and reported to facility executive leadership.	
	Complete skin assessments were performed within 24 hours of acute care admissions.	
X	Skin inspections and risk scales were performed upon transfer, change in condition, and discharge.	• Four of the 15 applicable 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 3 of the 16 EHRs, staff did not consistently document the location, stage, risk scale score, and/or the date acquired.
	Required activities were performed for patients determined to be at risk for pressure ulcers and for patients with pressure ulcers.	
	Required activities were performed for patients determined to not be at risk for pressure ulcers.	
	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.	
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.	• Two of eight applicable EHRs did not contain evidence of wound care follow-up plans at discharge.

NC	Areas Reviewed (continued)	Findings
	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.	
	The facility defined requirements for staff pressure ulcer education, and acute care staff received training on how to administer the pressure ulcer risk scale, conduct the complete skin assessment, and accurately document findings.	
	The facility complied with selected fire and environmental safety, infection prevention, and medication safety and security requirements in pressure ulcer patient rooms.	
	The facility complied with any additional elements required by VHA or local policy.	

Recommendations

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

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

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

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 33 training files, and we conversed with key employees. Additionally, we reviewed the actual nursing hours per patient day for acute medical/surgical unit 3M, the CLC unit, and mental health unit 4B 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.	

Construction Safety

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

We reviewed documentation for projects to correct electrical deficiencies and replace physical access security systems. We did not conduct project site inspections as the work being done at the time did not involve patient care areas. Additionally, we reviewed relevant documents and 20 training records (10 contractor records and 10 employee records), and we conversed with key employees and managers. The table below shows the areas reviewed for this topic. The areas marked as NC needed improvement. Any items that did not apply to this facility are marked NA.

NC	Areas Reviewed	Findings
	There was a multidisciplinary committee to oversee infection control and safety precautions during construction and renovation activities and a policy outlining the responsibilities of the committee, and the committee included all required members.	
	Infection control, preconstruction, interim life safety, and contractor tuberculosis risk assessments were conducted prior to project initiation.	
	There was documentation of results of contractor tuberculosis skin testing and of follow-up on any positive results.	
	There was a policy addressing Interim Life Safety Measures, and required Interim Life Safety Measures were documented.	
X	Site inspections were conducted by the required multidisciplinary team members at the specified frequency and included all required elements.	Site inspection documentation for 2 quarters reviewed: • Documentation did not include time of inspections, type of corrective action for identified deficiencies, and date and time of corrective actions.
X	ICC minutes documented infection surveillance activities associated with the project(s) and any interventions.	ICC minutes for past 2 quarters reviewed: • There was no documentation of infection surveillance activities related to any construction project prior to the most recent meeting.
	Construction Safety Committee minutes documented any unsafe conditions found during inspections and any follow-up actions and tracked actions to completion.	
	Contractors and designated employees received required training.	
NA	Dust control requirements were met.	

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

Recommendations

14. We recommended that processes be strengthened to ensure that documentation of construction site inspections includes time of inspections, type of corrective action for identified deficiencies, and date and time of corrective actions.

15. We recommended that processes be strengthened to ensure that infection surveillance activities related to construction projects are conducted and documented in ICC minutes.

Facility Profile (Fargo/437) FY 2013 through April 2013[a]	
Type of Organization	Secondary
Complexity Level	2-Medium complexity
Affiliated/Non-Affiliated	Affiliated
Total Medical Care Budget in Millions	$174.2
Number (through May 2013) of:	
• **Unique Patients**	26,683
• **Outpatient Visits**	167,403
• **Unique Employees**[b]	761
Type and Number of Operating Beds:	
• **Hospital**	46
• **CLC**	38
• **Mental Health**	10
Average Daily Census:	
• **Hospital**	20
• **CLC**	29
• **Mental Health**	5
Number of Community Based Outpatient Clinics	9
Location(s)/Station Number(s)	Grafton/437GA Bismarck/437GB Fergus Falls/437GC Minot/437GD Bemidji/437GE Williston/437GF Jamestown/437GG Dickinson/437GH Grand Forks/437GI
VISN Number	23

[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	67.0	71.5	55.3	59.3	58.3	62.1
VISN	66.9	70.5	57.9	59.3	58.7	60.4
VHA	63.9	65.0	55.0	54.7	54.3	55.0

Hospital Outcome of Care Measures

Hospital Outcome of Care Measures show what happened after patients with certain conditions received hospital care.[c] Mortality (or death) rates focus on whether patients died within 30 days of being hospitalized. Readmission rates focus on whether patients were hospitalized again within 30 days of their discharge. These rates are based on people who are 65 and older and are "risk-adjusted" to take into account how sick patients were when they were initially admitted. Table 2 below shows facility and U.S. national Hospital Outcome of Care Measure rates for patients discharged between July 1, 2008, and June 30, 2011.[d]

Table 2

	Mortality			Readmission		
	Heart Attack	Heart Failure	Pneumonia	Heart Attack	Heart Failure	Pneumonia
Facility	14.9	9.7	10.7	20.1	20.2	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: July 31, 2013

From: Director, VA Midwest Health Care Network (10N23)

Subject: **CAP Review of the Fargo VA Health Care System, Fargo, ND**

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

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

The purpose of this Memorandum is to submit the Director's comments to Office of Inspector General's Draft Report of CAP Review of the Fargo VA Health Care System, Fargo, ND.

(original signed by:)
JANET P. MURPHY, MBA
Network Director, VISN 23

Enclosure

Acting Facility Director Comments

Department of Veterans Affairs **Memorandum**

Date: July 31, 2013

From: Acting Director, Fargo VA Health Care System (437/00)

Subject: **CAP Review of the Fargo VA Health Care System, Fargo, ND**

To: Director, VA Midwest Health Care Network (10N23)

1. The purpose of this Memorandum is to submit the Director's comments to the Office of Inspector General's Draft Report of CAP Review at the Fargo VA Health Care System, Fargo, ND.

2. If you have any questions or would like to discuss this response, please contact me at 701-239-3701.

Dale DeKrey

DALE P. DEKREY, MS
Acting Medical Center Director

Enclosure

Comments to OIG's Report

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

OIG Recommendations

Recommendation 1. We recommended that processes be strengthened to ensure that FPPEs for newly hired LIPs are consistently initiated.

Concur

Target date for completion: November 1, 2013 (for continued monitoring)

Facility response:

The process for ensuring that FPPEs for newly hired LIPs is initiated was completed in October, 2012 to include: (Records that were reviewed were from 2011)

1. New LIP's Credentialing and Privileging application and FPPE plan is forwarded to the Professional Stands Board (PSB) for initial review.
2. On approval of the of the C&P and FPPE plan by the PSB, it is then forwarded to the Medical Executive Committee (MEC) for final approval and documented in the meeting minutes.
3. The Medical Center Director approves for final appointment.
4. Following the appointment a copy of the approved privileges and FPPE form are sent to the Service Line Chief for initiation.
5. A diary of the approval is maintained in the Medical Staff Office.
6. A 30 day follow-up is conducted with the Service Line Chief to assess completion of the FPPE.
7. Final reports of the FPPE results are forwarded to the PSB.

Ongoing compliance is monitored by the Medical Staff Coordinator and reported to the PSB and Medical Executive Council.

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

Concur

Target date for completion: January 15, 2014

Facility response:

The process to ensure that the results and scanning of those results into the EHR of non-VA purchased care was reviewed. The process going forward will include:

1. Following the payment of a bill, the business office clerks will review each line item and request the results for each diagnostic test that may have been performed.
2. The medical facility that completed the test(s) will be instructed to forward all results directly to the Medical Records Scanning department.
3. The Business Office Manager will complete monthly audits to ensure the process is effective. The expectation will be to review 20% of the patients medical records that received non-VA purchased care with a minimum of 90% compliance for 4 consecutive months.
4. Reports will be presented at the monthly Compliance meeting.

Recommendation 3. We recommended that the facility develop instructions for inspections of automated dispensing machines and that compliance be monitored.

Concur

Target date for completion: November 15, 2013

Facility response:

Instructions for inspection of automated dispensing machines have been developed and have been added to the orientation packet. Education will be given to the current CSI's on the new instructions.

Recommendation 4. We recommended that processes be strengthened to ensure that all CS inspectors complete the CS Drug-Diversion Inspection Certification prior to beginning CS inspections and annually and that all CS inspectors receive annual updates and refresher training and that compliance be monitored.

Concur

Target date for completion: January 16, 2014

Facility response:

All new Controlled Substance Inspectors (CSI) will complete the TMS training prior to performing inspections. All CSI will complete the TMS training annually.

The Controlled Substance Coordinator (CSC) will keep a printed copy of each inspector's certification in personnel file.

The CSC will conduct an annual refresher training which will include any pertinent updates.

The CSC will observe each inspector performing an inspection annually. A competency checklist will be developed and completed annually with the expectation of 100% compliance.

Training progress and final results will be presented at the OPC meeting.

Recommendation 5. We recommended that processes be strengthened to ensure that 1 day's dispensing from the pharmacy to each automated unit is consistently reconciled and that a hard copy order for at least 2 randomly selected dispensing activities is verified and that compliance be monitored.

Concur

Target date for completion: January 15, 2013

Facility response:

The CSC will provide training on current policy for verification of medications and reconciling of the automatic dispensing units as well as, the required documentation.

The CSC will revise the Inspection checklist to include these elements including the documentation requirements.

The Controlled Substance Coordinator (CSC) will monitor compliance, with the expectation that 100% compliance for 4 consecutive months will be achieved. Report will be presented monthly at the Organizational Performance Council (OPC).

Recommendation 6. We recommended that processes be strengthened to ensure that inspectors consistently verify the number of prescription pads and that 72-hour inventories of the main vault are consistently performed and that compliance be monitored.

Concur

Target date for completion: December 15, 2013

Facility response:

To ensure that inspectors verify the number of prescription pads the Inventory Log has been updated to include an inventory count column; the controlled substance inspector will initial the column at each inspection.

To ensure that the 72-hour inventories of the main vault are consistently performed the CSI will sign and date each 72 hour inventory report.

The Controlled Substance Coordinator will perform monthly audits to ensure logs have been completed accurately. 100% compliance with be achieved for 4 consecutive months.

Recommendation 7. We recommended that processes be strengthened to ensure that physical counts of all pharmacy drugs are completed during the 1st month of the quarter and that compliance be monitored.

Concur

Target date for completion: December 15, 2013

Facility response:

To ensure that physical counts of all pharmacy drugs have been completed during the 1st month of the quarter the CSI checklist will be revised to include documentation of the opening and replacement of the yellow seal on the emergency pharmacy supply cage and date that the counts were completed within the first month of each quarter.

The Controlled Substance Coordinator (CSC) will monitor compliance, with the expectation that 100% compliance for 4 consecutive months will be achieved. Report will be presented monthly at the Organizational Performance Council (OPC).

Recommendation 8. We recommended that processes be strengthened to ensure that inspectors verify hard copy prescriptions for 10 percent of the schedule II drugs dispensed in the outpatient pharmacy and that compliance be monitored.

Concur

Target date for completion: January 15, 2014

Facility response:

To ensure that inspectors verify hard copy prescriptions for 10 percent of the schedule II drugs dispensed in the outpatient pharmacy the CSI will initial each medication that he/she verifies. The CSI will sign and date the bottom of each page of the report.

The CSC will provide training on current policy for verification of medications.

The Controlled Substance Coordinator will perform monthly audits to ensure logs have been completed accurately. 100% compliance with be achieved for 4 consecutive months.

Recommendation 9. We recommended that processes be strengthened to ensure that drugs held for destruction are consistently compared with the Destruction File Holding Report, that inspectors consistently verify drug destructions are completed at least quarterly, and that inspectors ensure audit trails for destruction of 10 randomly selected drugs are consistently verified and that compliance be monitored.

Concur

Target date for completion: January 15, 2014

Facility response:

The CSI monthly checklist will be revised to include documentation of the last 3 destruction dates to verify they have been completed quarterly. In addition, the CSI will sign and date the VA form 10-2321 monthly which is reconciled with the destruction file holding report.

The Controlled Substance Coordinator will perform monthly audits to ensure logs have been completed accurately. 100% compliance with be achieved for 4 consecutive months.

Recommendation 10. We recommended that processes be strengthened to ensure that inspector competencies are documented and that inspectors date and initial inspection documents at the time of inspection and that compliance be monitored.

Concur

Target date for completion: November 15, 2013

Facility response:

The CSC will validate the CSI's competencies through annual observations of each inspector, and will include verification that each CSI is dating and initialing each inspection document at the time of inspection.

Competencies will be documented and maintained by the CSC. Copies of each competency will be also maintained in each inspectors personnel file.

Recommendation 11. We recommended that processes be strengthened to ensure that acute care staff perform and document a patient skin inspection and risk scale at discharge and that compliance be monitored.

Concur

Target date for completion: January 15, 2014

Facility response:

The inpatient nursing discharge template is being revised to include completion of Braden skin assessment at time of discharge; if it had not been previously completed the day of discharge. Following revision of the template, the discharge notes of patients discharged with a pressure ulcer will be a reviewed as part of an established pressure ulcer review, which will be reported at the Pressure Ulcer Management and Prevention Committee and Nurse Executive Council.

Recommendation 12. We recommended that processes be strengthened to ensure that acute care staff accurately document location, stage, risk scale score, and the date the pressure ulcer was acquired for all patients with pressure ulcers and that compliance be monitored.

Concur

Target date for completion: January 15, 2014

Facility response:

Further training is being provided for the nursing staff on the inpatient unit regarding the assessment and documentation of pressure ulcers. Completed training will be tracked for 100% nursing staff completion and post training monitoring of pressure ulcer documentation and accuracy will be conducted as part the established pressure ulcer review, results will be reported at the Pressure Ulcer Management and Prevention Committee and Nurse Executive Council.

Recommendation 13. We recommended that processes be strengthened to ensure that all patients discharged with pressure ulcers have wound care follow-up plans and that compliance be monitored.

Concur

Target date for completion: January 15, 2014

Facility response:

The inpatient nursing discharge note is being revised to include a section to document the wound care follow up plan for those patients discharged with a pressure ulcer. Following revision of the template, the discharge notes of patients discharged with a pressure ulcer will be a reviewed as part of an established pressure ulcer review, which will be reported at the Pressure Ulcer Management and Prevention Committee and Nurse Executive Council.

Recommendation 14. We recommended that processes be strengthened to ensure that documentation of construction site inspections includes time of inspections, type of corrective action for identified deficiencies, and date and time of corrective actions.

Concur

Target date for completion: January 15, 2014

Facility response:

Beginning July 16, 2013, the Construction Safety Committee held its first post inspection meeting and discussed the recommendations in the finding. The Committee appointed the Engineering Administrative Assistant to accompany rounds to document

the construction round findings in a formalized tracker document. A deficiency tracker tool has been developed to document Construction Safety rounds. The tool includes time of inspections, type of corrective action for identified deficiencies and date and time of corrective actions. The effectiveness of the tool was tested on July 16, 23, and 30, 2013. Final improvements to the form were made July 31, 2013 and will be utilized for rounds starting August 6, 2013.

Results will be reported at the Construction Safety Committee to track all identified actions to closure. The next monthly schedule Construction Safety Committee is August 14, 2013.

The Chief of Engineering will conduct compliance monitoring for four consecutive months to ensure that all elements of the tracking tool have been completed.

Recommendation 15. We recommended that processes be strengthened to ensure that infection surveillance activities related to construction projects are conducted and documented in ICC minutes.

Concur

Target date for completion: April 15, 2014

Facility response:

A deficiency tracker tool has been developed to document Construction Safety rounds. The effectiveness of the tool was tested on July 16, 23, and 30, 2013. The tracker tool identifies all deficiencies including infection control issues and provides recommended solutions. Final improvements to the form were made July 31, 2013 and will be utilized for rounds documentation starting August 6, 2013.

This form will be utilized to report Infection Control deficiencies as they relate to construction projects at the quarterly Infection Control Meeting with identified solutions outlined. All issues including identified solutions will be tracked to completion and will be documented in the Infection Control Meeting Minutes.

Due to the fact that the Infection Control Committee meets quarterly (next is scheduled for September 10, 2013), the Infection Control Coordinator will conduct monitoring to ensure compliance for 9 months; or 3 consecutive quarterly meetings.

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Endnotes

[1] References used for this topic included:
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- VHA Handbook 1050.01, *VHA National Patient Safety Improvement Handbook*, March 4, 2011.
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- VHA Directive 2009-026, *Location, Selection, Installation, Maintenance, and Testing of Emergency Eyewash and Shower Equipment*, May 13, 2009.
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[3] References used for this topic included:
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- 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:
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- 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.
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- VHA Directive 2009-053, *Pain Management*, October 28, 2009.
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[5] References used for this topic included:
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- Various requirements of The Joint Commission.
- Agency for Healthcare Research and Quality Guidelines.
- National Pressure Ulcer Advisory Panel Guidelines.
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[6] The references used for this topic were:
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[7] References used for this topic included:
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- Various Centers for Disease Control and Prevention recommendations and guidelines, Joint Commission standards, and Occupational Safety and Health Administration (OSHA) regulations.