Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 13-01975-292

Combined Assessment Program Review of the VA Central California Health Care System Fresno, California

August 27, 2013

Washington, DC 20420

To Report Suspected Wrongdoing in VA Programs and Operations
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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	VA Central California Health Care System
FY	fiscal year
HPC	hospice and palliative care
MH	mental health
NA	not applicable
NC	noncompliant
OIG	Office of Inspector General
PCCT	Palliative Care Consult Team
QM	quality management
RME	reusable medical equipment
SPS	Sterile Processing Service
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

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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 17, 2013.

Review Results: The review covered seven activities. The facility's reported accomplishments were the Systems Redesign collaborative, a safety program, and an end-of-life program.

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

Quality Management: Consistently perform continued stay reviews on at least 75 percent of patients in acute beds.

Environment of Care: Ensure floors in patient care areas are clean, and store clean and dirty items separately. Require that Sterile Processing Service employees responsible for reprocessing receive annual competency assessments and that reusable medical equipment standard operating procedures are consistent with manufacturers' instructions.

Medication Management – Controlled Substances Inspections: Consistently conduct bi-weekly inventories of automated dispensing machines, and complete daily end of shift counts for non-automated dispensing units. Amend the inspection checklist to include all required items, and ensure inspectors perform drug destruction and audit trail verification oversight.

Coordination of Care – Hospice and Palliative Care: Ensure that the Palliative Care Consult Team includes a dedicated social worker and a dedicated psychologist or other mental health provider and that all non-hospice and palliative care clinical staff who provide care to patients at the end of their lives receive end-of-life training.

Pressure Ulcer Prevention and Management: Ensure that staff consistently document location, stage, risk score, and/or date pressure ulcer acquired for all patients with pressure ulcers, that all discharged pressure ulcer patients have wound care follow-up plans and receive dressing supplies prior to being discharged, and that dietary screening and assessment of patients with pressure ulcers is consistent with facility policy.

Nurse Staffing: Fully implement the nurse staffing methodology.

Construction Safety: Ensure designated employees receive ongoing construction safety training.

Comments

The Veterans Integrated Service Network and Facility Directors agreed with the Combined Assessment Program review findings and recommendations and provided acceptable improvement plans. (See Appendixes C and D, pages 20–28, for the full text of the Directors' comments.) We consider recommendations 3 and 15 closed. We will follow up on the planned actions for the open recommendations until they are completed.

JOHN D. DAIGH, JR., MD.
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 17, 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 VA Central California Health Care System, Fresno, California,* Report No.10-01081-135, April 22, 2010).

During this review, we presented crime awareness briefings for 249 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 254 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

Systems Redesign

In FY 2012, the facility implemented a Systems Redesign improvement with the urology clinic's successful participation in the Surgical and Specialty Care Collaborative. With the aim of improving access to outpatient urology care, the interdisciplinary team streamlined clinic operations, redefined staff roles and responsibilities, and enhanced team cohesiveness. As a result, the team improved access for new patients from more than 60 days to approximately 12 days. Clinic staff also adopted new methodologies such as electronic consults, daily huddles, and the use of a care coordinator. In June 2012, the team's efforts and successes achieved were presented at a national learning session.

Red Wave Safety Program

The *Red Wave* program is an innovative approach to assist veterans who have a high risk of falling or have health conditions that make it difficult to walk. Team members wear bright red shirts to make them easily recognizable to the approximately 1,300 veterans they assist each day. The team consists of volunteers and work-study program participants and embodies VHA's strategic goal of providing personalized, proactive, and patient-centered care. Members of the team provide curbside service and assist patients from their cars into the facility. The program helped decrease the outpatient fall rate by 50 percent in FY 2011, and the rate has continued to drop. The facility's *Red Wave* program won the American Spirit Award and was named as a best practice VA-wide.

End-of-Life—*No Veteran Dies Alone* Program

The facility's *No Veteran Dies Alone* program was designed to honor and meet the needs of veterans who are alone as they are nearing the end of life. A trained group of dedicated veteran and employee volunteers provides presence, companionship, and reassurance to any veteran at the end of life. When family and friends are unable to be

with a veteran at the end of life or a hospice patient is in need of companionship, volunteers sit at the bedside to help ease loneliness, anxiety, or restlessness. On December 12, 2011, the facility's program was profiled on the television show "CBS Evening News" with Scott Pelley.

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 area marked as NC needed improvement. Any items that did not apply to this facility are marked NA.

NC	Areas Reviewed	Findings
	There was a senior-level committee/group responsible for QM/performance improvement, and it included the required members.	
	There was evidence that Inpatient Evaluation Center data was discussed by senior managers.	
	Corrective actions from the protected peer review process were reported to the Peer Review Committee.	
	Focused Professional Practice Evaluations for newly hired licensed independent practitioners complied with selected requirements.	
NA	Local policy for the use of observation beds complied with selected requirements.	
NA	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.	
X	Staff performed continuing stay reviews on at least 75 percent of patients in acute beds.	Three quarters of continuing stay data reviewed: • For all 3 quarters, less than 75 percent of acute inpatients were reviewed.
	Appropriate processes were in place to prevent incidents of surgical items being retained in a patient following surgery.	
	The cardiopulmonary resuscitation review policy and processes complied with requirements for reviews of episodes of care where resuscitation was attempted.	
	There was an EHR quality review committee, and the review process complied with selected requirements.	
	The EHR copy and paste function was monitored.	

NC	Areas Reviewed (continued)	Findings
	Appropriate quality control processes were in place for non-VA care documents, and the documents were scanned into EHRs.	
	Use and review of blood/transfusions complied with selected requirements.	
	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.	

Recommendation

1. We recommended that processes be strengthened to ensure that continued stay reviews are consistently performed on at least 75 percent of patients in acute beds.

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 four inpatient care areas (an acute care unit, the intensive care unit, the locked MH unit, and the CLC), the emergency department, primary care (pod D), the specialty care area, and SPS. Additionally, we reviewed relevant documents, conversed with key employees and managers, and reviewed competency files for 10 hemodialysis contractors and 4 SPS employees. The facility provided bedside hemodialysis only. The table below shows the areas reviewed for this topic. The areas marked as NC needed improvement. Any items that did not apply to this facility are marked NA.

NC	Areas Reviewed for General EOC	Findings
	EOC Committee minutes reflected sufficient detail regarding identified deficiencies, corrective actions taken, and tracking of corrective actions to closure.	
	An infection prevention risk assessment was conducted, and actions were implemented to address high-risk areas.	
	Infection Prevention/Control Committee minutes documented discussion of identified problem areas and follow-up on implemented actions and included analysis of surveillance activities and data.	
	Fire safety requirements were met.	
X	Environmental safety requirements were met.	• Two of the seven patient care areas inspected had dirty floors.
X	Infection prevention requirements were met.	• In three of the seven patient areas inspected, clean and dirty items were not stored separately.
	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.	

NC	Areas Reviewed for Hemodialysis (continued)	Findings
	Monthly biological water and dialysate testing was conducted and included required components, and identified problems were corrected.	
	Contractors received training on bloodborne pathogens.	
	Contractor hand hygiene monitoring was conducted, and any needed corrective actions were implemented.	
NA	Selected EOC/infection prevention/safety requirements were met in the hemodialysis clinic.	
	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.	
	Areas Reviewed for SPS/RME	
	The facility had policies/procedures/guidelines for cleaning, disinfecting, and sterilizing RME.	
	The facility used an interdisciplinary approach to monitor compliance with established RME processes, and RME-related activities were reported to an executive-level committee.	
NA	The facility had policies/procedures/guidelines for immediate use (flash) sterilization and monitored it.	
X	Employees received required RME training and competency assessment.	• All 4 SPS employees had been on duty for more than 2 years; there was no evidence that 2 received all applicable annual competency assessments.
NA	Operating room employees who performed immediate use (flash) sterilization received training and competency assessment.	
X	RME standard operating procedures were consistent with manufacturers' instructions, procedures were located where reprocessing occurs, and sterilization was performed as required.	RME standard operating procedures, manufacturers' instructions, and 1 day of sterilization logs for 3 RME items reviewed: • Two of the standard operating procedures were not consistent with manufacturers' instructions.
	Selected infection prevention/environmental safety requirements were met.	
	Selected requirements for SPS decontamination and sterile storage areas were met.	
	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.	

Recommendations

2. We recommended that processes be strengthened to ensure that floors in patient care areas are clean and that compliance be monitored.

3. We recommended that processes be strengthened to ensure that clean and dirty items are stored separately.

4. We recommended that processes be strengthened to ensure that SPS employees responsible for reprocessing activities receive annual competency assessments.

5. We recommended that processes be strengthened to ensure that RME standard operating procedures are consistent with manufacturers' instructions.

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 both CS Coordinators and 11 CS inspectors and inspection documentation from 11 CS areas, the inpatient and outpatient pharmacies, and the emergency drug cache. The table below shows the areas reviewed for this topic. The areas marked as NC needed improvement. Any items that did not apply to this facility are marked NA.

NC	Areas Reviewed	Findings
	Facility policy was consistent with VHA requirements.	
	VA police conducted annual physical security surveys of the pharmacy/pharmacies, and any identified deficiencies were corrected.	
X	Instructions for inspecting automated dispensing machines were documented, included all required elements, and were followed.	Automated dispensing machine inspection instructions reviewed: • Although instructions required bi-weekly inventories of automated dispensing machines, they were not consistently conducted.
	Monthly CS inspection findings summaries and quarterly trend reports were provided to the facility Director.	
	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 11 CS areas inspected during the past 6 months reviewed: • Daily end of shift counts for non-automated dispensing units were not done at the Tulare clinic. Instead, a count was done only when a CS was dispensed.

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: • The pharmacy inspection checklist for CS inspectors was missing two required components—verification of quarterly drug destruction and verification of the audit trail for destruction of 10 randomly selected drugs. Instead, the CS Coordinator or alternate witnessed all drugs that were turned in for destruction.
	The facility complied with any additional elements required by VHA or local policy.	

Recommendations

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

7. We recommended that processes be strengthened to ensure that end of shift counts for non-automated dispensing units are completed daily and that compliance be monitored.

8. We recommended that the inspection checklist be amended to include all required items and that processes be strengthened to ensure that inspectors perform drug destruction and audit trail verification oversight 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 28 employee training records (3 HPC staff records and 25 non-HPC staff records), and we conversed with key employees. The table below shows the areas reviewed for this topic. The areas marked as NC needed improvement. Any items that did not apply to this facility are marked NA.

NC	Areas Reviewed	Findings
X	A PCCT was in place and had the dedicated staff required.	List of staff assigned to the PCCT reviewed: • A social worker and psychologist or other MH provider had not been dedicated to the PCCT.
	The PCCT actively sought patients appropriate for HPC.	
	The PCCT offered end-of-life training.	
X	HPC staff and selected non-HPC staff had end-of-life training.	• There was no evidence that eight 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.	

NC	Areas Reviewed (continued)	Findings
	The facility complied with any additional elements required by VHA or local policy.	

Recommendations

9. We recommended that processes be strengthened to ensure that the PCCT includes a dedicated social worker and a dedicated psychologist or other MH provider.

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

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, 21 EHRs of patients with pressure ulcers (10 patients with hospital-acquired pressure ulcers, 10 patients with community-acquired pressure ulcers, and 1 patient with a pressure ulcer 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.	
	Skin inspections and risk scales were performed upon transfer, change in condition, and discharge.	
X	Staff were generally consistent in documenting location, stage, risk scale score, and date acquired.	• In five of the 21 EHRs, staff did not consistently document the location, stage, risk scale score, and/or date acquired.
	Required activities were performed for patients determined to be at risk for pressure ulcers and for patients with pressure ulcers.	
	Required activities were performed for patients determined to not be at risk for pressure ulcers.	
	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.	• None of the four applicable EHRs contained evidence of wound care follow-up plans at discharge or evidence that patients received dressing supplies prior to 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.	
X	The facility complied with any additional elements required by VHA or local policy.	Local policies on nutrition and wound care reviewed: • Nutrition and Food Service's procedure regarding who performs dietary screening and assessment of pressure ulcer patients was inconsistent with facility policy.

Recommendations

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

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

13. We recommended that processes be strengthened to ensure that the dietary screening and assessment of patients with pressure ulcers is consistent with facility policy 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 we conversed with key employees. The table below shows the areas reviewed for this topic. The area marked as NC needed improvement. Any items that did not apply to this facility are marked NA.

NC	Areas Reviewed	Findings
X	The facility completed the required steps to develop a nurse staffing methodology by the deadline.	• The facility had not fully implemented the staffing methodology.
NA	The unit-based expert panels followed the required processes and included all required members.	
NA	The facility expert panel followed the required processes and included all required members.	
NA	Members of the expert panels completed the required training.	
NA	The actual nursing hours per patient day met or exceeded the target nursing hours per patient day.	
	The facility complied with any additional elements required by VHA or local policy.	

Recommendation

14. We recommended that the facility fully implement the nurse staffing methodology.

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 inspected the dental clinic expansion project. Additionally, we reviewed relevant documents and 12 employee training records, and we conversed with key employees and managers. 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
	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.	
NA	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.	
	Site inspections were conducted by the required multidisciplinary team members at the specified frequency and included all required elements.	
	Infection Control Committee minutes documented infection surveillance activities associated with the project(s) and any interventions.	
	Construction Safety Committee minutes documented any unsafe conditions found during inspections and any follow-up actions and tracked actions to completion.	
X	Contractors and designated employees received required training.	Employee training records reviewed: • Two employee records did not contain evidence of at least 10 hours of construction safety-related training in the past 2 years.
	Dust control requirements were met.	
	Fire and life safety requirements were met.	
	Hazardous chemicals requirements were met.	
	Storage and security requirements were met.	

NC	Areas Reviewed (continued)	Findings
	The facility complied with any additional elements required by VHA or local policy or other regulatory standards.	

Recommendation

15. We recommended that processes be strengthened to ensure that designated employees receive ongoing construction safety training and that compliance be monitored.

Facility Profile (Fresno/570) 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	$195.1
Number (through May 2013) of:	
• **Unique Patients**	25,625
• **Outpatient Visits**	234,092
• **Unique Employees[b]**	919
Type and Number of Operating Beds:	
• **Hospital**	57
• **CLC**	60
• **MH**	12
Average Daily Census:	
• **Hospital**	45
• **CLC**	47
• **MH**	7
Number of Community Based Outpatient Clinics	3
Location(s)/Station Number(s)	Merced/570GA Tulare/570GB Oakhurst/570GC
VISN Number	21

[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

Fresno, CA	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	67.7	62.4	58.4	57.0	55.7	56.1
VISN	70.1	61.9	58.1	55.8	57.4	59.1
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	15.9	16.6	14.6	19.7	27.8	17.3
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 8, 2013

From: Director, Sierra Pacific Network (10N21)

Subject: **CAP Review of the VA Central California Health Care System, Fresno, CA**

To: Director, Los Angeles Office of Healthcare Inspections (54LA)

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

1. Thank you for the opportunity to review the draft OIG CAP report for Central California Health Care System.

2. Attached is the action plan developed by the facility. I am confident that actions developed will ensure full compliance with all of the recommendations.

3. If you have any questions, please contact Terry Sanders Associate Quality Manager for VISN 21 at (707) 562-8370.

Sheila Cullen
Attachments

Facility Director Comments

Department of Veterans Affairs **Memorandum**

Date: August 5, 2013

From: Director, VA Central California Health Care System (570/00)

Subject: **CAP Review of the VA Central California Health Care System, Fresno, CA**

To: Director, Sierra Pacific Network (10N21)

1. I appreciate the opportunity to provide our input to the VA-OIG Combined Assessment Program (CAP) review of our health care system which took place during the week of June 17, 2013.

2. I concur with all the findings and suggested improvement actions.

3. On behalf of our health care system, I would like to express my thanks to the OIG-CAP review team which visited our facility. We found the team members not only fair in their assessments, but very helpful throughout our preparatory activities and during the review itself.

4. We appreciate the important feedback we received from this review and will use the information to further strengthen our administrative and clinical operations.

Sincerely,

Joanne M. Krumberger
Director

Comments to OIG's Report

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

OIG Recommendations

Recommendation 1. We recommended that processes be strengthened to ensure that continued stay reviews are consistently performed on at least 75 percent of patients in acute beds.

Concur

Target date for completion: November 1, 2013

Facility response:

In February 2013, a System Redesign "100-Day" project was implemented by the healthcare system to realize efficiencies within facility utilization management processes. Final recommendations were approved in May 2013, with a new Bed Management Team initiated in July 2013. Utilization management activities were expanded from one RN completing utilization reviews to four RNs managing utilization reviews as well as bed control and patient transfer activities.

All members of the new Bed Management Team have received initial training in use of InterQual criteria; it will take several months for all members of the team to optimize their efficiencies in use of these criteria. Efficiencies will also be optimized in the technical aspects of the UM review process, which includes use of NUMI software. At the end of June 2013, the FY13 average rate of completion for continued stay reviews for patients in acute beds was 26.3 percent. The goal is to consistently perform continued stay reviews on at least 75 percent of patients in acute beds. Results will be monitored and reported quarterly to the Quality Council.

Recommendation 2. We recommended that processes be strengthened to ensure that floors in patient care areas are clean and that compliance be monitored.

Concur

Target date for completion: November 30, 2013

Facility response:

Environmental Management has developed a Unit Based Environment of Care program and action plan to ensure patient care areas are clean and within compliance. The program ensures real time assessments with follow up of cleaning needs. The Internal inspection processes are underway of redesign, allowing for third party inspection processes to be implemented with established follow ups with continuous monitoring.

Work verification will be measured and accomplished according to VA of Central California Health Care system standard operating procedures.

Reassessment of staffing and coverage capabilities is underway and will be accomplished by October 31, 2013 with action items implemented by November 30, 2013.

Recommendation 3. We recommended that processes be strengthened to ensure that clean and dirty items are stored separately.

Concur

Target date for completion: Completed June 28, 2013

Facility response:

Staff has been re-educated to ensure all clean and dirty items are properly/separately stored. The Emergency Services department provided re-education to the staff on June 21, 2013 and implemented a process to ensure clean items are stored separately from dirty items.

On the inpatient medical units (5E), the correct process for storage of clean equipment, such as IV poles, was reviewed with all staff during staff meeting on June 28, 2013 through email notifications, and via shift huddles. Real time education to staff members also occurs as need arises. Signage has been appropriately placed as visual cues to ensure processes are maintained.

Unit managers and charge nurses ensure items are stored properly by completing a check list for every shift. Breaks in process will be immediately corrected and reported via the 24 hour report. Environment of Care rounds also ensures clean and dirty item storage is kept separate.

Recommendation 4. We recommended that processes be strengthened to ensure that SPS employees responsible for reprocessing activities receive annual competency assessments.

Concur

Target date for completion: August 15, 2013

Facility response:

SPS technician's competencies are maintained in the SPS Chief's office. The competencies are reviewed annually. The Chief and Assistant Chief of SPS are currently reviewing all SPS staff competencies.

Recommendation 5. We recommended that processes be strengthened to ensure that RME standard operating procedures are consistent with manufacturers' instructions.

Concur

Target date for completion: October 1, 2013

Facility response:

The Chief and Assistant Chief have developed a review process to ensure all Re-usable Medical Equipment (RME) standard operating procedures (SOPs) are consistent with manufacturer's instructions. The full review will be completed by September 25, 2013. A cross comparison will be completed for updated RME SOPs and/or updated manufacturer's instructions. RME SOPs and manufacturer instruction crosswalk will be completed by October 1, 2013 and annually thereafter.

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

Concur

Target date for completion: October 1, 2013

Facility response:

The Nurse Managers in areas with Pyxis units have re-educated their staff on the processes to complete the inventory count and will check these areas to assure bi-weekly compliance. An electronic report will be printed and reviewed monthly by the controlled substance coordinator to monitor compliance. Ongoing monitoring for compliance will continue through October 1, 2013.

Recommendation 7. We recommended that processes be strengthened to ensure that end of shift counts for non-automated dispensing units are completed daily and that compliance be monitored.

Concur

Target date for completion: October 1, 2013

Facility response:

The CBOC nurse managers have educated their staff on the daily end-of-shift count process. The nurse manager at the CBOC Tulare location will also send a photocopy of the daily count record VA Form 10-1043 to Chief Nurse Executive as well as the Controlled Substance Inspection Coordinator every other week, which will be included in the monthly report to the Facility Director.

Recommendation 8. We recommended that the inspection checklist be amended to include all required items and that processes be strengthened to ensure that inspectors perform drug destruction and audit trail verification and that compliance be monitored.

Concur

Target date for completion: July 31, 2013

Facility response:

Although 100% of drug destruction is witnessed by the controlled substance inspection coordinator monthly, a separate audit of 10 randomly-selected drugs for destruction will be completed each month to meet VHA policy. The controlled substance inspectors will ensure this process occurs by comparing the destruction holding report with the inventory receipt issued by the contracting destruction agency. The current controlled substance inspectors assigned to this inspection zone (i.e. pharmacy) have been educated accordingly. The controlled substance inspection coordinator will also verify compliance each month.

Recommendation 9. We recommended that processes be strengthened to ensure that the PCCT includes a dedicated social worker and a dedicated psychologist or other MH provider.

Concur

Target date for completion: September 30, 2013

Facility response:

After consultation with the National Director of Hospice and Palliative Care regarding the requirements for Palliative Care Consult Team (PCCT) staffing, it was determined that the hiring of a Licensed Clinical Social Worker (LCSW) can meet the requirements for PCCT psychosocial staffing.

The Palliative Care team has initiated the recruitment process for a dedicated LCSW. The target date to fill the LCSW position for the Palliative Care Team is by September 30, 2013.

Recommendation 10. We recommended that processes be strengthened to ensure that all non-HPC clinical staff who provide care to patients at the end of their lives receive end-of-life training.

Concur

Target date for completion: September 30, 2013

Facility response:

A facility wide educational plan has been put into place to ensure all non-HPC clinical staff who provides care to end-of-life patients receives end-of-life training.

This training will be monitored through the Talent Management System (TMS). Each service-line Chief, Supervisor and/or Manager will ensure training is completed by September 30, 2013 and annually thereafter.

For new employees who provide end-of-life care, the end-of-life training is addressed at new employee orientation.

Recommendation 11. We recommended that processes be strengthened to ensure that acute care staff consistently document location, stage, risk scale score, and/or date pressure ulcer acquired for all patients with pressure ulcers and that compliance be monitored.

Concur

Target date for completion: August 1, 2013 for current staff and ongoing thereafter.

Facility response:

Licensed nursing staff has completed the National Database of Nursing Quality Indicators (NDNQI) Pressure Ulcer module. Newly hired licensed nursing staff will receive the NDNQI Pressure Ulcer module as part of the new hire orientation and annually thereafter.

To ensure compliance, Unit Managers or designees will review 100% of admission records over a four consecutive month time frame, to ensure compliance with both the local and national pressure ulcer policies.

The data will be reported to the monthly Veterans Experience Performance Excellence Council (VEPEC).

Recommendation 12. We recommended that processes be strengthened to ensure that all patients discharged with pressure ulcers have wound care follow-up plans and receive dressing supplies prior to being discharged and that compliance be monitored.

Concur

Target date for completion: August 1, 2013

Facility response:

Wound nurses provide written wound care recommendations, which includes wound care supply list for 100% of patients with pressure ulcers. The wound care nurse team

audits 100% of all patients who are discharged with pressure ulcers to ensure appropriate follow up plans and supplies are provided to the patient.

For all patients with pressure ulcers, physicians complete the Discharge Instructions which includes wound care instructions/guidance. Pharmacy orders are placed for wound care supplies until the patient is seen by the Primary Care provider or for a follow-up surgical clinic appointment.

The discharging nurse reviews the wound care instructions and confirms appropriate wound care supplies have been ordered.

The data will be reported to the monthly Veterans Experience Performance Excellence Council (VEPEC).

Recommendation 13. We recommended that processes be strengthened to ensure that the dietary screening and assessment of patients with pressure ulcers is consistent with facility policy and that compliance be monitored.

Concur

Target date for completion: November 1, 2013

Facility response:

Healthcare System policy has been updated to ensure the appropriate process for dietary screening and assessment of patients with pressure ulcers is in place. To ensure correct process is followed, the Nutrition and Food Services department is providing in-servicing to the nursing team regarding the process improvements.

The process has been strengthened to ensure the following: patients identified by nursing staff with a Braden Scale score of 16 or below will be referred to the dietitian for nutritional assessment within 24 hours. Patients not identified by nursing to be at nutritional risk will be visited and screened by the clinical dietetic technician within 3 days of admission. Patients will be screened based on nutrition-related criteria which include skin integrity. Based on this information, patients are assigned one of the following nutrition risk-status levels: Normal, Mildly Compromised, Moderately Compromised, or Severely Compromised. Nutritional Assessments will be performed by the dietitian based on Nutrition and Food Services Memorandum No. C2: Medical Nutrition Therapy Inpatient Practice Guidelines. The dietitian completes a nutritional assessment within 24 hours after patient is identified at high-risk by nursing.

The Chief of Nutrition and Food Services, or designee, will monitor compliance by completing 20 dietitian chart reviews per month.

All HCSM updates and in-servicing will be completed by November 1, 2013. The data will be reported at the monthly Veterans Experience Performance Excellence Council (VEPEC).

Recommendation 14. We recommended that the facility fully implement the nurse staffing methodology.

Concur

Target date for completion: September 30, 2013

Facility response:

The Unit-Based Expert Panels and data collection processes are in place. The Facility-Based Expert Panel (FEBP) team members have been confirmed. The staffing indicator review and recalculation of Staffing Methodology has been completed.

Full implementation of the Nurse Staffing Methodology will be in place by September 30, 2013.

Recommendation 15. We recommended that processes be strengthened to ensure that designated employees receive ongoing construction safety training and that compliance be monitored.

Concur

Target date for completion: July 17, 2013

Facility response:

Engineering and Safety Service coordinated an OSHA 10-hour course for all full-time employees who are involved in construction-related activities. This included the Purchase and Hire employees, and Maintenance & Repair employees. This training was provided to the employees on July 15th and 17th, 2013.

This training will be monitored and tracked using Talent Management System (TMS), where the curriculum will be added to all applicable employee profiles. TMS provides timely alerts to employees and supervisors. The Engineering Service secretary tracks training deadlines to ensure completion.

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Endnotes

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