Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 13-02312-304

Combined Assessment Program Review of the Cheyenne VA Medical Center Cheyenne, Wyoming

September 11, 2013

Washington, DC 20420

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

Glossary

CAP	Combined Assessment Program
CLC	community living center
CS	controlled substances
EHR	electronic health record
EOC	environment of care
facility	Cheyenne VA Medical Center
FY	fiscal year
HPC	hospice and palliative care
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 July 8, 2013.

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

- Environment of Care
- Medication Management – Controlled Substances Inspections
- Coordination of Care – Hospice and Palliative Care

The facility's reported accomplishments were the Cheyenne VAMC (VA medical center) and Clinics Planning Model and improvements in the Controlled Substances Inspection Program.

Recommendations: We made recommendations in the following three activities:

Quality Management: Consistently scan the results of non-VA purchased diagnostic tests into electronic health records. Ensure all required members participate in Transfusion Review/Lab Utilization Review Committee meetings.

Pressure Ulcer Prevention and Management: Establish a policy for pressure ulcer prevention. Establish an interprofessional pressure ulcer committee, and ensure the committee reports program data to facility executive leadership. Perform and document a complete skin inspection and risk scale at discharge. Accurately document location, stage, and/or risk scale score for all patients with pressure ulcers. Perform and document daily risk scales for patients at risk for or with pressure ulcers. Establish patient/caregiver and staff pressure ulcer education requirements.

Nurse Staffing: Fully implement the nurse staffing methodology.

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 14–18, for the full text of the Directors' comments.) We will follow up on the planned actions until they are completed.

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

Objectives and Scope

Objectives

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

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

Scope

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

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

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

The review covered facility operations for FY 2012 and FY 2013 through July 12, 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 Cheyenne VA Medical Center, Cheyenne, Wyoming,* Report No. 11-01297-222, July 12, 2011).

During this review, we presented crime awareness briefings for 42 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 252 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

Cheyenne VAMC[a] and Clinics Planning Model

The Cheyenne VAMC and Clinics Planning Model incorporated Resources, Strategic Vision/Planning/Initiatives, and Data/Performance Improvement. Identified by the facility as one of three key FY 2013 strategic initiatives, the model has been incorporated into every level of decision making. It provides transparency in facility decision making and empowers service chiefs in the decision making process.

CS Inspection Program

In December 2012, the CS Inspection Program was completely restructured by a newly appointed CS Coordinator. The goals were a smaller, more efficient, and well-trained inspection team and concise and understandable reporting and trending. A new training manual was developed, and one-to-one training was completed with each inspector, which included hands-on and didactic instruction. Results of CS inspections are reported to the facility Director and include monthly and quarterly tracking sheets as well as detailed reasons for discrepancies, analyses, and documented resolutions. CS inspectors have reported increased satisfaction with the restructured program, and there has been a decrease in the amount of time spent by inspectors in this well-organized, concisely reported program.

[a] VAMC stands for VA medical center.

Results and Recommendations

QM

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

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

NC	Areas Reviewed	Findings
	There was a senior-level committee/group responsible for QM/performance improvement, and it included the required members.	
	There was evidence that Inpatient Evaluation Center data was discussed by senior managers.	
	Corrective actions from the protected peer review process were reported to the Peer Review Committee.	
	Focused Professional Practice Evaluations for newly hired licensed independent practitioners complied with selected requirements.	
	Local policy for the use of observation beds complied with selected requirements.	
	Data regarding appropriateness of observation bed use was gathered, and conversions to acute admissions were less than 30 percent, or the facility had reassessed observation criteria and proper utilization.	
	Staff performed continuing stay reviews on at least 75 percent of patients in acute beds.	
	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
X	Appropriate quality control processes were in place for non-VA care documents, and the documents were scanned into EHRs.	Twenty-two EHRs of patients who had non-VA purchased diagnostic tests reviewed: • Five test results were not scanned into the EHRs.
X	Use and review of blood/transfusions complied with selected requirements.	Twelve months of the Transfusion Review/Lab Utilization Review Committee meeting minutes reviewed: • There was no evidence that Medicine and Anesthesia Services were represented at committee meetings.
	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 the results of non-VA purchased diagnostic tests are consistently scanned into EHRs.

2. We recommended that all required members participate in Transfusion Review/Lab Utilization Review Committee meetings.

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 two CLCs and the intensive care and medical/surgical units. We also inspected the primary and specialty care clinics, the emergency department, and SPS. Additionally, we reviewed relevant documents, conversed with key employees and managers, and reviewed 12 employee training and competency files (7 operating room and 5 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	
NA	The facility had policy detailing the cleaning and disinfection of hemodialysis equipment and environmental surfaces and the management of infection prevention precautions patients.	
NA	Monthly biological water and dialysate testing were conducted and included required components, and identified problems were corrected.	

NC	Areas Reviewed for Hemodialysis (continued)	Findings
NA	Employees received training on bloodborne pathogens.	
NA	Employee hand hygiene monitoring was conducted, and any needed corrective actions were implemented.	
NA	Selected EOC/infection prevention/safety requirements were met.	
NA	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.	
	Areas Reviewed for SPS/RME	
	The facility had policies/procedures/guidelines for cleaning, disinfecting, and sterilizing RME.	
	The facility used an interdisciplinary approach to monitor compliance with established RME processes, and RME-related activities were reported to an executive-level committee.	
	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 9 CS areas, the inpatient and outpatient pharmacies, and the emergency drug cache. 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
	Facility policy was consistent with VHA requirements.	
	VA police conducted annual physical security surveys of the pharmacy/pharmacies, and any identified deficiencies were corrected.	
	Instructions for inspecting automated dispensing machines were documented, included all required elements, and were followed.	
	Monthly CS inspection findings summaries and quarterly trend reports were provided to the facility Director.	
	CS Coordinator position descriptions or functional statements included duties, and CS Coordinators completed required certification and were free from conflicts of interest.	
	CS inspectors were appointed in writing, completed required certification and training, and were free from conflicts of interest.	
	Non-pharmacy areas with CS were inspected in accordance with VHA requirements, and inspections included all required elements.	
	Pharmacy CS inspections were conducted in accordance with VHA requirements and included all required elements.	
	The facility complied with any additional elements required by VHA or local policy.	

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 20 employee training records (5 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, 7 EHRs of patients with pressure ulcers (1 patient with a hospital-acquired pressure ulcer and 6 patients with community-acquired pressure ulcers), and 10 employee training records. The table below shows the areas reviewed for this topic. The areas marked as NC needed improvement. Any items that did not apply to this facility are marked NA.

NC	Areas Reviewed	Findings
X	The facility had a pressure ulcer prevention policy, and it addressed prevention for all inpatient areas and for outpatient care.	• The facility had not developed a policy.
X	The facility had an interprofessional pressure ulcer committee, and the membership included a certified wound care specialist.	• The facility did not have an interprofessional pressure ulcer committee.
X	Pressure ulcer data was analyzed and reported to facility executive leadership.	• There was no documentation that pressure ulcer data was 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 seven 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 six of the seven EHRs, the location, stage, and/or risk scale score were not documented consistently.
X	Required activities were performed for patients determined to be at risk for pressure ulcers and for patients with pressure ulcers.	• Staff did not consistently document performing daily risk scales in any of the seven EHRs.
NA	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.	
	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.	

NC	Areas Reviewed (continued)	Findings
X	The facility defined requirements for patient and caregiver pressure ulcer education, and education on pressure ulcer prevention and development was provided to those at risk for and with pressure ulcers and/or their caregivers.	• The facility had not developed patient and/or caregiver pressure ulcer education requirements.
X	The facility defined requirements for staff pressure ulcer education, and acute care staff received training on how to administer the pressure ulcer risk scale, conduct the complete skin assessment, and accurately document findings.	• The facility had not developed staff pressure ulcer education requirements.
NA	The facility complied with selected fire and environmental safety, infection prevention, and medication safety and security requirements in pressure ulcer patient rooms.	
NA	The facility complied with any additional elements required by VHA or local policy.	

Recommendations

3. We recommended that the facility establish a policy for pressure ulcer prevention, establish an interprofessional pressure ulcer committee, and ensure that the interprofessional pressure ulcer committee reports program data to facility executive leadership.

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

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

6. We recommended that processes be strengthened to ensure that acute care staff perform and document daily risk scales for patients at risk for or with pressure ulcers and that compliance be monitored.

7. We recommended that the facility establish patient/caregiver and staff pressure ulcer education requirements and that compliance be monitored.

Nurse Staffing

The purpose of this review was to determine the extent to which the facility implemented the staffing methodology for nursing personnel and to evaluate nurse staffing on two inpatient units (acute medical/surgical and long-term care).[6]

We reviewed relevant documents and 10 training files, and we interviewed key employees. The table below shows the areas reviewed for this topic. The area marked as NC needed improvement. Any items that did not apply to this facility are marked NA.

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

Recommendation

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

Facility Profile (Cheyenne/442) FY 2013 through May 2013[b]	
Type of Organization	Secondary
Complexity Level	2-Medium complexity
Affiliated/Non-Affiliated	Affiliated
Total Medical Care Budget in Millions	$112.5
Number (through June 2013) of: • **Unique Patients**	 18,349
• **Outpatient Visits**	159,041
• **Unique Employees**[c]	713
Type and Number of Operating Beds: • **Hospital**	 22
• **CLC**	42
• **Mental Health**	NA
Average Daily Census: • **Hospital**	 13
• **CLC**	13
• **Mental Health**	NA
Number of Community Based Outpatient Clinics	4
Locations/Station Numbers	Sidney, NE/442GB Fort Collins, CO/442GC Greeley, CO/442GD Cheyenne, WY/442HK
VISN Number	19

[b] All data is for FY 2013 through May 2013 except where noted.
[c] 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 scores for quarters 3–4 of FY 2012 and quarters 1–2 of FY 2013 and overall outpatient satisfaction scores for FY 2012.

Table 1

	Inpatient Scores		**Outpatient Scores**			
	FY 2012	**FY 2013**	**FY 2012**			
	Inpatient Score Quarters 3–4	Inpatient Score Quarters 1–2	Outpatient Score Quarter 1	Outpatient Score Quarter 2	Outpatient Score Quarter 3	Outpatient Score Quarter 4
Facility	67.3	71.4	58.8	59.0	53.1	57.9
VISN	64.3	63.5	51.5	53.0	51.6	52.5
VHA	65.0	65.5	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.[d] 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.[e]

Table 2

	Mortality			Readmission		
	Heart Attack	Heart Failure	Pneumonia	Heart Attack	Heart Failure	Pneumonia
Facility	**	10.3	9.5	**	23.9	20.3
U.S. National	15.5	11.6	12.0	19.7	24.7	18.5

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

[d] 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.

[e] 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 21, 2013

From: Director, Rocky Mountain Network (10N19)

Subject: **CAP Review of the Cheyenne VA Medical Center, Cheyenne, WY**

To: Director, Denver Office of Healthcare Inspections (54DV)

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

I have reviewed and concur on the submission from the Director, Cheyenne VA Medical Center. If you have any questions, please contact Ms. Susan Curtis, VISN 19 HSS at (303) 639-6995.

Appendix D

Facility Director Comments

Department of Veterans Affairs **Memorandum**

Date: August 7, 2013

From: Director, Cheyenne VA Medical Center (442/00)

Subject: **CAP Review of the Cheyenne VA Medical Center, Cheyenne, WY**

To: Director, Rocky Mountain Network (10N19)

1. The Cheyenne VAMC would like to express our appreciation for the opportunity to work with the Office of Inspector General and to review and comment regarding the recommendations for improvement contained in this report.

2. Please find attached our response to each recommendation provided in this report.

3. If there are any questions regarding the response to the recommendations or any additional information is required, please contact Ms. Lisa Adamson, Chief of Quality Management, (307) 433-3621 or at Lisa.Adamson@va.gov.

Medical Center Director

Comments to OIG's Report

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

OIG Recommendations

Recommendation 1. We recommended that processes be strengthened to ensure that the results of non-VA purchased diagnostic tests are consistently scanned into EHRs.

Concur

Target date for completion: September 9, 2013

Facility response: Processes have been discussed with the Network Authorization Office, our partner in non-VA care billing. Implementation of a plan that will directly import scanned results is in progress.

Recommendation 2. We recommended that all required members participate in Transfusion Review/Lab Utilization Review Committee meetings.

Concur

Target date for completion: August 2013

Facility response: Members have been notified by the Chief of Staff and attendance will be tracked and reported to Medical Executive Board and Executive Quality Board until 100% compliance is reported a minimum of three months.

Recommendation 3. We recommended that the facility establish a policy for pressure ulcer prevention, establish an interprofessional pressure ulcer committee, and ensure that the interprofessional pressure ulcer committee reports program data to facility executive leadership.

Concur

Target date for completion: August 30, 2013

Facility response: A facility policy has been developed that defines the committee and how reporting will be completed.

Recommendation 4. We recommended that processes be strengthened to ensure that acute care staff perform and document a complete skin inspection and risk scale at discharge and that compliance be monitored.

Concur

Target date for completion: August 30, 2013

Facility response: Processes defined in facility policy and monitoring to take place via medical record reviews and reported through the Medical Records Committee. Education and competencies have been completed by acute care staff.

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

Concur

Target date for completion: August 30, 2013

Facility response: Processes defined in facility policy and monitoring to take place via medical record reviews and reported through the Medical Records Committee. Education and competencies have been completed by acute care staff.

Recommendation 6. We recommended that processes be strengthened to ensure that acute care staff perform and document daily risk scales for patients at risk for or with pressure ulcers and that compliance be monitored.

Concur

Target date for completion: August 30, 2013

Facility response: Processes defined in facility policy and monitoring to take place via medical record reviews and reported through the Medical Records Committee. Education and competencies have been completed by acute care staff.

Recommendation 7. We recommended that the facility establish patient/caregiver and staff pressure ulcer education requirements and that compliance be monitored.

Concur

Target date for completion: September 30, 2013

Facility response: Competencies have been completed by appropriate staff and will be completed annually and monitored by the Nurse Educator.

Recommendation 8. We recommended that the facility fully implement the nurse staffing methodology.

Concur

Target date for completion: August 30, 2013

Facility response: A policy has been developed that identifies the processes for nurse staffing methodology in order to meet all requirements. All members will complete level 1 and 2 training by target date and new members will complete training prior to

participation in the workgroup. NHPPD Tracker is in place and tracking and trending will be reported quarterly to the Nurse Executive Board.

OIG Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the OIG at (202) 461-4720.
Onsite Contributors	Laura Dulcie, BSEE, Team Leader Stephanie Hensel, RN, JD Randy Rupp Virginia Solana, RN, MA Cheryl Walker, ARNP, MBA
Other Contributors	Elizabeth Bullock Shirley Carlile, BA Paula Chapman, CTRS Lin Clegg, PhD Marnette Dhooghe, MS Matt Frazier, MPH Jeff Joppie, BS Victor Rhee, MHS Julie Watrous, RN, MS Jarvis Yu, MS

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U.S. Senate: John Barrasso, Michael F. Bennett, Michael B. Enzi, Deb Fischer, Mike Johanns, Mark Udall
U.S. House of Representatives: Cory Gardner, Cynthia M. Lummis, Jared Polis, Adrian Smith

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

Endnotes

[1] References used for this topic included:
- VHA Directive 2009-043, *Quality Management System*, September 11, 2009.
- VHA Handbook 1050.01, *VHA National Patient Safety Improvement Handbook*, March 4, 2011.
- VHA Directive 2010-017, *Prevention of Retained Surgical Items*, April 12, 2010.
- VHA Directive 2010-025, *Peer Review for Quality Management*, June 3, 2010.
- VHA Directive 2010-011, *Standards for Emergency Departments, Urgent Care Clinics, and Facility Observation Beds*, March 4, 2010.
- VHA Directive 2009-064, *Recording Observation Patients*, November 30, 2009.
- VHA Handbook 1100.19, *Credentialing and Privileging*, November 14, 2008.
- VHA Directive 2008-063, *Oversight and Monitoring of Cardiopulmonary Resuscitative Events and Facility Cardiopulmonary Resuscitation Committees,* October 17, 2008.
- VHA Handbook 1907.01, *Health Information Management and Health Records*, September 19, 2012.
- VHA Directive 6300, Records Management, July 10, 2012.
- VHA Directive 2009-005, *Transfusion Utilization Committee and Program*, February 9, 2009.
- VHA Handbook 1106.01, *Pathology and Laboratory Medicine Service Procedures*, October 6, 2008.
- VHA Handbook 1142.03, *Requirements for Use of the Resident Assessment Instrument (RAI) Minimum Data Set (MDS)*, January 4, 2013.

[2] References used for this topic included:
- VHA Directive 2011-007, *Required Hand Hygiene Practices*, February 16, 2011.
- VHA Directive 2009-004, *Use and Reprocessing of Reusable Medical Equipment (RME) in Veterans Health Administration Facilities*, February 9, 2009.
- VHA Directive 2009-026*, Location, Selection, Installation, Maintenance, and Testing of Emergency Eyewash and Shower Equipment*, May 13, 2009.
- VA National Center for Patient Safety, "Look-Alike Hemodialysis Solutions," Patient Safety Alert 11-09, September 12, 2011.
- VA National Center for Patient Safety, "Multi-Dose Pen Injectors," Patient Safety Alert 13-04, January 17, 2013.
- Various requirements of The Joint Commission, the Centers for Disease Control and Prevention, the Occupational Safety and Health Administration, the National Fire Protection Association, the American National Standards Institute, the Association for the Advancement of Medical Instrumentation, the International Association of Healthcare Central Service Materiel Management, and the Association for Professionals in Infection Control and Epidemiology.

[3] References used for this topic included:
- VHA Handbook 1108.01, *Controlled Substances (Pharmacy Stock)*, November 16, 2010.
- VHA Handbook 1108.02, *Inspection of Controlled Substances*, March 31, 2010.
- VHA Handbook 1108.05, *Outpatient Pharmacy Services*, May 30, 2006.
- VHA Handbook 1108.06, *Inpatient Pharmacy Services*, June 27, 2006.
- VHA, "Clarification of Procedures for Reporting Controlled Substance Medication Loss as Found in VHA Handbook 1108.01," Information Letter 10-2011-004, April 12, 2011.
- VA Handbook 0730, *Security and Law Enforcement*, August 11, 2000.
- VA Handbook 0730/2, *Security and Law Enforcement*, May 27, 2010.

[4] References used for this topic included:
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