Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 13-02643-20

Combined Assessment Program Review of the James H. Quillen VA Medical Center Mountain Home, Tennessee

November 22, 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	James H. Quillen VA Medical Center
FY	fiscal year
HPC	hospice and palliative care
IC	infection control
MH	mental health
NA	not applicable
NC	noncompliant
NCPS	National Center for Patient Safety
OIG	Office of Inspector General
OR	operating room
PCCT	Palliative Care Consult Team
PU	pressure ulcer
QM	quality management
RME	reusable medical equipment
SPS	Sterile Processing Service
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

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Executive Summary

Review Purpose: The purpose of the review was to evaluate selected health care facility operations, focusing on patient care quality and the environment of care, and to provide crime awareness briefings. We conducted the review the week of September 23, 2013.

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

- Coordination of Care – Hospice and Palliative Care
- Pressure Ulcer Prevention and Management
- Nurse Staffing
- Construction Safety

The facility's reported accomplishments were performance improvement projects, the Patient Safety Program, and the decrease in the incidence of hospital-acquired pressure ulcers.

Recommendations: We made recommendations in the following three activities:

Quality Management: Ensure code reviews include screening for clinical issues prior to non-intensive care unit codes that may have contributed to the occurrence of the cardiopulmonary event. Consistently scan the results of non-VA purchased diagnostic tests into electronic health records.

Environment of Care: Correct the identified environmental safety hazards on the locked mental health unit related to equipment, furniture, and anchor points, and routinely test all panic alarms on the unit. Ensure that operating room employees who perform immediate use sterilization receive annual competency assessments.

Medication Management – Controlled Substances Inspections: Consistently reconcile 1 day's dispensing from the pharmacy to each automated unit, and consistently complete pharmacy inspections on the same day they were initiated.

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 18–22, for the full text of the Directors' comments.) We will follow up on the planned actions until they are completed.

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

Objectives and Scope

Objectives

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

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

Scope

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

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

- QM
- EOC
- Medication Management – CS Inspections
- Coordination of Care – HPC
- PU 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 September 23, 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 James H. Quillen VA Medical Center, Mountain Home, Tennessee,* Report No. 08-03076-161, July 10, 2009).

During this review, we presented crime awareness briefings for 67 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 470 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

Performance Excellence Awards and Activities

The facility received the Secretary of VA Robert W. Carey Performance Excellence Award and the Tennessee Center for Performance Excellence Achievement Award for 2 consecutive years—2011 and 2012. In FY 2013, staff completed 233 performance improvement projects. These projects resulted in 20,323 man hours saved and a projected cost savings of more than $754,790.

Patient Safety Program

The facility's commitment to patient safety is evident through numerous awards and activities. The facility's Patient Safety Program received gold-level recognition from the NCPS for having a strong root cause analysis process in place for the last 3 years. After participating in training provided by the NCPS to address safety issues related to failures in communication in 2012, the facility partnered with the NCPS to become the first medical center based training facility. In addition, in 2012, the facility scored the second highest of all medical centers (98 percent) on a national employee safety perception survey.

Risk Surveillance and Early Prevention of PUs

Establishment of a facility-wide culture of rapid response PU risk surveillance and early prevention has resulted in marked improvement in the incidence of PUs in all inpatient and outpatient care areas. In FY 2012, the hospital-acquired PU rate decreased

98 percent and has remained low at only 0.3 percent. Accuracy in nursing documentation of patients' skin condition has improved from 43 percent to almost 100 percent, and medical provider documentation of patients' skin condition has increased from 0 percent to 72 percent.

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.	
X	The cardiopulmonary resuscitation review policy and processes complied with requirements for reviews of episodes of care where resuscitation was attempted.	Six months of Special Care Committee meeting minutes reviewed: • There was no evidence that code reviews included screening for clinical issues prior to non-intensive care unit codes that may have contributed to the occurrence of the code.
	There was an EHR quality review committee, and the review process complied with selected requirements.	

NC	Areas Reviewed (continued)	Findings
	The EHR copy and paste function was monitored.	
X	Appropriate quality control processes were in place for non-VA care documents, and the documents were scanned into EHRs.	Twenty five EHRs of patients who had non-VA purchased diagnostic tests reviewed: • Thirteen test results 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 Special Care Committee code reviews include screening for clinical issues prior to non-intensive care unit codes that may have contributed to the occurrence of the cardiopulmonary event.

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

EOC

The purpose of this review was to determine whether the facility maintained a clean and safe health care environment in accordance with applicable requirements and whether selected requirements in the hemodialysis and SPS areas were met.[2]

We inspected the medical/telemetry, medical/surgical/oncology, specialty care, progressive care, hemodialysis, and locked MH units. We also inspected the emergency department, chemotherapy clinic, CLC, and SPS area. Additionally, we reviewed relevant documents, conversed with key employees and managers, and reviewed 25 employee training and competency files (4 hemodialysis, 11 OR, and 10 SPS). The table below shows the areas reviewed for this topic. The areas marked as NC needed improvement. Any items that did not apply to this facility are marked NA.

NC	Areas Reviewed for General EOC	Findings
	EOC Committee minutes reflected sufficient detail regarding identified deficiencies, corrective actions taken, and tracking of corrective actions to closure.	
	An infection prevention risk assessment was conducted, and actions were implemented to address high-risk areas.	
	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.	The locked MH unit had the following safety hazards: • In the dining room, two sets of audiovisual equipment were unsecured and on top of rolling carts. • The dining room tables and chairs were not heavily weighted or secured to the floor, and there was no plan to ensure patient safety in this area. • A piano in the dining room had metal pieces on the sides that could be used as anchor points for self-harm by hanging. • Routine testing of the portable panic alarms was not done. • The panic alarm located in the nursing station had not been tested for the past 6 months.
	Infection prevention requirements were met.	
	Medication safety and security requirements were met.	
	Sensitive patient information was protected, and patient privacy requirements were met.	

NC	Areas Reviewed for General EOC (continued)	Findings
	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 were conducted and included required components, and identified problems were corrected.	
	Employees received training on bloodborne pathogens.	
	Employee hand hygiene monitoring was conducted, and any needed corrective actions were implemented.	
	Selected EOC/infection prevention/safety requirements were met.	
	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.	
	Areas Reviewed for SPS/RME	
	The facility had policies/procedures/guidelines for cleaning, disinfecting, and sterilizing RME.	
	The facility used an interdisciplinary approach to monitor compliance with established RME processes, and RME-related activities were reported to an executive-level committee.	
	The facility had policies/procedures/guidelines for immediate use (flash) sterilization and monitored it.	
	Employees received required RME training and competency assessment.	
X	OR employees who performed immediate use (flash) sterilization received training and competency assessment.	• There was no evidence that any of the 8 OR employees on duty for more than 2 years received annual competency assessments.
	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.	

NC	Areas Reviewed for SPS/RME (continued)	Findings
	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

3. We recommended that the identified environmental safety hazards on the locked MH unit related to equipment, furniture, and anchor points be corrected and that compliance be monitored.

4. We recommended that processes be strengthened to ensure that all panic alarms on the locked MH unit are routinely tested and that compliance be monitored.

5. We recommended that processes be strengthened to ensure that OR employees who perform immediate use sterilization receive annual competency assessments.

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.	Automated dispensing machine inspection instructions reviewed: • Although instructions required reconciliation of 1 day's dispensing from the pharmacy to each automated unit, this was not completed for 2 of 6 months in the 10 selected non-pharmacy areas.
	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.	
	Non-pharmacy areas with CS were inspected in accordance with VHA requirements, and inspections included all required elements.	
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: • Pharmacy inspections were not completed on the same day they were initiated for 2 of 12 inspections.
	The facility complied with any additional elements required by VHA or local policy.	

Recommendations

6. 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 compliance be monitored.

7. We recommended that processes be strengthened to ensure that pharmacy inspections are consistently completed on the same day they were initiated 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. The facility generally met requirements. We made no recommendations.

NC	Areas Reviewed	Findings
	A PCCT was in place and had the dedicated staff required.	
	The PCCT actively sought patients appropriate for HPC.	
	The PCCT offered end-of-life training.	
	HPC staff and selected non-HPC staff had end-of-life training.	
	The facility had a VA liaison with community hospice programs.	
	The PCCT promoted patient choice of location for hospice care.	
	The CLC-based hospice program offered bereavement services.	
	The HPC consult contained the word “palliative” or “hospice” in the title.	
	HPC consults were submitted through the Computerized Patient Record System.	
	The PCCT responded to consults within the required timeframe and tracked consults that had not been acted upon.	
	Consult responses were attached to HPC consult requests.	
	The facility submitted the required electronic data for HPC through the VHA Support Service Center.	
	An interdisciplinary team care plan was completed for HPC inpatients within the facility’s specified timeframe.	
	HPC inpatients were assessed for pain with the frequency required by local policy.	
	HPC inpatients’ pain was managed according to the interventions included in the care plan.	
	HPC inpatients were screened for an advanced directive upon admission and according to local policy.	
	The facility complied with any additional elements required by VHA or local policy.	

PU Prevention and Management

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

We reviewed relevant documents, 14 EHRs of patients with PUs (4 patients with hospital-acquired PUs, 7 patients with community-acquired PUs, and 3 patients with PUs at the time of our onsite visit), and 10 employee training records. Additionally, we inspected three patient rooms. The table below shows the areas reviewed for this topic. 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 had a PU prevention policy, and it addressed prevention for all inpatient areas and for outpatient care.	
	The facility had an interprofessional PU committee, and the membership included a certified wound care specialist.	
	PU data was analyzed and reported to facility executive leadership.	
	Complete skin assessments were performed within 24 hours of acute care admissions.	
	Skin inspections and risk scales were performed upon transfer, change in condition, and discharge.	
	Staff were generally consistent in documenting location, stage, risk scale score, and date acquired.	
	Required activities were performed for patients determined to be at risk for PUs and for patients with PUs.	
NA	Required activities were performed for patients determined to not be at risk for PUs.	
	For patients at risk for and with PUs, interprofessional treatment plans were developed, interventions were recommended, and EHR documentation reflected that interventions were provided.	
	If the patient's PU was not healed at discharge, a wound care follow-up plan was documented, and the patient was provided appropriate dressing supplies.	
	The facility defined requirements for patient and caregiver PU education, and education on PU prevention and development was provided to those at risk for and with PUs and/or their caregivers.	

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

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 23 training files, and we conversed with key employees. Additionally, we reviewed the actual nursing hours per patient day for acute medical/surgical unit C1, CLC unit CLC1, and MH unit E1 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 IC and safety precautions during construction and renovation activities in accordance with applicable standards.[7]

We inspected renovation projects for the CLC and primary care areas. Additionally, we reviewed relevant documents and 32 training records (21 contractor records and 11 employee records), and we conversed with key employees and managers. 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
	There was a multidisciplinary committee to oversee IC and safety precautions during construction and renovation activities and a policy outlining the responsibilities of the committee, and the committee included all required members.	
	IC, 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.	
	Site inspections were conducted by the required multidisciplinary team members at the specified frequency and included all required elements.	
	IC Committee minutes documented infection surveillance activities associated with the project and any interventions.	
	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.	
	Dust control requirements were met.	
	Fire and life safety requirements were met.	
	Hazardous chemicals requirements were met.	
	Storage and security requirements were met.	
	The facility complied with any additional elements required by VHA or local policy or other regulatory standards.	

Facility Profile (Mountain Home/621) FY 2013 through August 2013[a]	
Type of Organization	Secondary
Complexity Level	1c-High complexity
Affiliated/Non-Affiliated	Affiliated
Total Medical Care Budget in Millions	$366.5
Number (through September 2013) of:	
• **Unique Patients**	51,569
• **Outpatient Visits**	569,269
• **Unique Employees**[b]	1,811
Type and Number of Operating Beds:	
• **Hospital**	114
• **CLC**	120
• **MH**	170
Average Daily Census:	
• **Hospital**	78
• **CLC**	62
• **MH**	109
Number of Community Based Outpatient Clinics	7
Location(s)/Station Number(s)	Knoxville/621BY Rogersville/621GA Norton/621GC St. Charles/621GD Morristown/621GG Sevierville/621GI Bristol/621GJ
VISN Number	9

[a] All data is for FY 2013 through August 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 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	72.0	81.3	60.8	54.5	59.3	56.7
VISN	65.1	64.5	54.7	54.1	55.8	55.2
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.[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, 2009, and June 30, 2012.[d]

Table 2

	Mortality			Readmission		
	Heart Attack	Heart Failure	Pneumonia	Heart Attack	Heart Failure	Pneumonia
Facility	14.3	9.9	9.6	*	*	*
U.S. National	15.5	11.6	12.0	19.7	24.7	18.5

* No data is available from the facility for this measure.

[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: November 8, 2013

From: Director, VA Mid South Healthcare Network (10N9)

Subject: **CAP Review of the James H. Quillen VA Medical Center, Mountain Home, TN**

To: Director, Bay Pines Office of Healthcare Inspections (54SP)

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

1. I concur with the findings and recommendations of this Office of Inspector General Combined Assessment Program Review of the James H. Quillen VA Medical Center, Mountain Home, Tennessee, as well as the action plan developed by the facility.

2. If you have any questions or need additional information from the Network, please do not hesitate to contact Joe Schoeck, Staff Assistant to the Network Director, at 615-695-2205 or me at 615-695-2206.

(original signed by:)
John E. Patrick

Facility Director Comments

Department of Veterans Affairs **Memorandum**

Date: November 6, 2013

From: Director, James H. Quillen VA Medical Center (621/00)

Subject: **CAP Review of the James H. Quillen VA Medical Center, Mountain Home, TN**

To: Director, VA Mid South Healthcare Network (10N9)

1. On behalf of the James H. Quillen VA Medical Center, Mountain Home, Tennessee, I concur with the findings and recommendations of this Office of Inspector General report. We had already been actively working to improve or enhance several of these areas and welcome the "fresh eyes" perspective provided by this report.

2. Included herein is an outline of improvement actions taken, in progress, or planned in response to these findings. We believe these changes will further enhance key systems and processes at our medical center.

Charlene S. Ehret, FACHE

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 Special Care Committee code reviews include screening for clinical issues prior to non-intensive care unit codes that may have contributed to the occurrence of the cardiopulmonary event.

Concur

Target date for completion: January 1, 2014

Facility response: The Special Care Committee added the screening for clinical issues prior to non-intensive care unit codes that may contribute to the occurrence of the cardiopulmonary event to the minute template. The minute template is addressed at each Special Care Committee meeting. The Chief, Quality Management will perform a quality audit of all Special Care Committee minutes and report to the Quality Executive Board to ensure 100 percent compliance for six months.

Recommendation 2. 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: January 1, 2014

Facility response: The process of scanning non-VA purchased diagnostic test results performed on Veterans was immediately reviewed and an additional scanner was obtained to ensure documentation is moved into the computerized patient record system. The Chief of Business Office is performing monthly quality audits to ensure 95 percent compliance is maintained. Thirty randomly selected NVCC claims will be viewed monthly. The September and October audit results were 100 percent compliant with clinical documentation scanned into NVCC package and EHR.

Recommendation 3. We recommended that the identified environmental safety hazards on the locked MH unit related to equipment, furniture, and anchor points be corrected and that compliance be monitored.

Concur

Target date for completion: January 1, 2014

Facility response: (1). Two sets of audiovisual equipment were removed and two new televisions which will be secured have been ordered. (2). The metal pieces on the piano were removed and replaced with rolling castors. (3). A policy was written on the Management of Veterans in the Dining/Activities Hall. This policy was shared with staff to ensure the dining hall is never left unsecured. The Nurse Manager will complete a monthly quality audit to ensure 100 percent compliance with the security of the dining room.

Recommendation 4. We recommended that processes be strengthened to ensure that all panic alarms on the locked MH unit are tested and that compliance be monitored.

Concur

Target date for completion: November 1, 2013

Facility response:

(1).The routine testing of the portable panic alarms are tested monthly. A Nurse Call System Badge Locators log was created. The Nurse Manager is completing a monthly quality audit to ensure 100 percent compliance with testing of portable panic alarms.

(2). The panic alarm located at the nursing station was placed on the VA Police duress alarm testing list and is being tested monthly. The Nurse Manager receives a copy of the monthly test and will perform a monthly quality audit to ensure 100 percent compliance.

Recommendation 5. We recommended that processes be strengthened to ensure that OR employees who perform immediate use sterilization receive annual competency assessments.

Concur

Target date for completion: October 7, 2013

Facility response: Twenty two OR employees (100 percent) who would perform immediate use sterilization received annual competency assessments on that specific process. The OR Manager placed this annual competency assessment on the scheduled annual competency plan to ensure completion each year.

Recommendation 6. 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 compliance be monitored.

Concur

Target date for completion: January 1, 2014

Facility response: The Controlled Substance Coordinator revised the inspection report form to clearly separate inside and outside vault (Pharmacy). All controlled substance inspectors were educated on the requirement to ensure that one day's dispensing from the pharmacy to each automated unit is consistently reconciled. A monthly monitoring tool was developed to track completion with one hundred percent of inspections. The October audit results were 100 percent compliant.

Recommendation 7. We recommended that processes be strengthened to ensure that pharmacy inspections are consistently completed on the same day they were initiated and that compliance be monitored.

Concur

Target date for completion: January 1, 2014

Facility response: The Controlled Substance Coordinator (CSC) re-educated all controlled substance inspectors that each inspection area must be completed on the day it is initiated. The CSC is responsible for reviewing all controlled substance monitoring reports to ensue controlled substance pharmacy inspections are consistently completed on the same day. A monthly monitoring tool was developed to ensure that one hundred percent of inspections are completed timely. The October audit results were 100 percent compliant.

OIG Contact and Staff Acknowledgments

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Non-VA Distribution

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Office of Management and Budget
U.S. Senate: Lamar Alexander, Bob Corker, Tim Kaine, Mark R. Warner
U.S. House of Representatives: Scott DesJarlais; John J. Duncan, Jr.; Chuck Fleischmann; Morgan Griffith; Phil Roe

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

Endnotes

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