Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 13-03649-52

Combined Assessment Program Review of the Michael E. DeBakey VA Medical Center Houston, Texas

January 24, 2014

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
COS	Chief of Staff
EHR	electronic health record
EOC	environment of care
facility	Michael E. DeBakey VA Medical Center
FPPE	Focused Professional Practice Evaluation
FY	fiscal year
MEC	Medical Executive Committee
MH	mental health
MSIT	Multidisciplinary Safety Inspection Team
NA	not applicable
NM	not met
OIG	Office of Inspector General
PRC	Peer Review Committee
QM	quality management
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 November 4, 2013.

Review Results: The review covered seven activities and one follow-up review area from the previous Combined Assessment Program review. We made no recommendations in the following two activities:

- Medication Management
- Coordination of Care

Recommendations: We made recommendations in the following five activities and follow-up review area:

Quality Management: Appoint the Chief of Staff as the chairperson of the Peer Review Committee. Consistently initiate Focused Professional Practice Evaluations for newly hired licensed independent practitioners, and report the results to the Medical Executive Committee. Perform continued stay reviews on at least 75 percent of patients in acute beds. Include the Chief of Staff as a member of the Operating Room Committee. Ensure the Blood Utilization Committee member from Surgery Service consistently attends meetings.

Environment of Care: Ensure patient care areas and restrooms are clean, and repair damaged towel dispensers, doors and doorframes, and floors and baseboards. Train all locked mental health unit staff and Multidisciplinary Safety Inspection Team members on identifying and correcting environmental hazards, proper use of the Mental Health Environment of Care Checklist, and VA's National Center for Patient Safety study of suicide on psychiatric units.

Nurse Staffing: Include all required members on the facility expert panel.

Pressure Ulcer Prevention and Management: Accurately document pressure ulcer location, stage, risk scale score, and date acquired for all patients with pressure ulcers.

Community Living Center Resident Independence and Dignity: Document restorative nursing initial weekly assessments.

Follow-Up on Environment of Care Rounds Attendance: Ensure all required participants or their designees consistently attend environment of care rounds.

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 21–26, for the full text of the Directors' comments.) We consider recommendation 9 closed. We will follow up on the planned actions for the open recommendations 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 and follow-up review area from the previous CAP review:

- QM
- EOC
- Medication Management
- Coordination of Care
- Nurse Staffing
- Pressure Ulcer Prevention and Management
- CLC Resident Independence and Dignity
- Follow-Up on EOC Rounds Attendance

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 FYs 2012, 2013, and 2014 through November 4, 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 Michael E. DeBakey VA Medical Center, Houston, Texas,* Report No. 09-03275-147, May 13, 2010). We made repeat recommendations in QM and EOC rounds attendance.

During this review, we presented crime awareness briefings for 273 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 327 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.

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 met 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 NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

NM	Areas Reviewed	Findings
	There was a senior-level committee/group responsible for QM/performance improvement that met regularly. • There was evidence that outlier data was acted upon. • There was evidence that QM, patient safety, and systems redesign were integrated.	
X	The protected peer review process met selected requirements: • The PRC was chaired by the COS and included membership by applicable service chiefs. • Actions from individual peer reviews were completed and reported to the PRC. • The PRC submitted quarterly summary reports to the MEC. • Unusual findings or patterns were discussed at the MEC.	Twenty months of PRC meeting minutes reviewed: • The COS was a member of the PRC but was not the chairperson.
X	FPPEs for newly hired licensed independent practitioners were initiated, completed, and reported to the MEC.	Seventy-eight profiles reviewed: • Fifteen FPPEs (19 percent) were not initiated. • None of the results of the 63 completed FPPEs were reported to the MEC. This was a repeat finding from the previous CAP review.
NA	Specific telemedicine services met selected requirements: • Services were properly approved. • Services were provided and/or received by appropriately privileged staff. • Professional practice evaluation information was available for review.	

NM	Areas Reviewed (continued)	Findings
	Observation bed use met selected requirements: • Local policy included necessary elements. • Data regarding appropriateness of observation bed usage was gathered. • If conversions to acute admissions were consistently 30 percent or more, observation criteria and utilization were reassessed timely.	
X	Staff performed continuing stay reviews on at least 75 percent of patients in acute beds.	Twelve months of continuing stay data reviewed: • For all 12 months, less than 75 percent of acute inpatients were reviewed.
	The process to review resuscitation events met selected requirements: • An interdisciplinary committee was responsible for reviewing episodes of care where resuscitation was attempted. • Resuscitation event reviews included screening for clinical issues prior to events that may have contributed to the occurrence of the code. • Data were collected that measured performance in responding to events.	
X	The surgical review process met selected requirements: • An interdisciplinary committee with appropriate leadership and clinical membership met monthly to review surgical processes and outcomes. • All surgical deaths were reviewed. • Additional data elements were routinely reviewed.	Twelve months of Operating Room Committee meeting minutes reviewed: • The COS was not a member.
	Critical incidents reporting processes were appropriate.	
	The process to review the quality of entries in the EHR met selected requirements: • A committee was responsible to review EHR quality. • Data were collected and analyzed at least quarterly. • Reviews included data from most services and program areas.	
	The policy for scanning non-VA care documents met selected requirements.	

NM	Areas Reviewed (continued)	Findings
X	The process to review blood/transfusions usage met selected requirements: • A committee with appropriate clinical membership met at least quarterly to review blood/transfusions usage. • Additional data elements were routinely reviewed.	Twelve months of the Blood Utilization Committee meeting minutes reviewed: • The clinical representative from Surgery Service attended only one of four meetings.
	Overall, if significant issues were identified, actions were taken and evaluated for effectiveness.	
	Overall, 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 met any additional elements required by VHA or local policy.	

Recommendations

1. We recommended that the COS be appointed as the chairperson of the PRC.

2. We recommended that processes be strengthened to ensure that FPPEs for newly hired licensed independent practitioners are consistently initiated and that results are reported to the MEC.

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

4. We recommended that the Operating Room Committee include the COS as a member.

5. We recommended that processes be strengthened to ensure that the Blood Utilization Committee member from Surgery Service consistently attends 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 radiology and acute MH were met.[2]

We inspected one medical, one surgical, one surgical intensive care, and one geriatric and acute psychiatry unit; two CLCs; a primary care and an audiology clinic; the emergency department; the domiciliary; and an x-ray and a fluoroscopy unit. Additionally, we reviewed relevant documents, conversed with key employees and managers, and reviewed 30 employee training records (10 radiology employees, 10 acute MH unit employees, 5 MSIT members, and 5 occasional acute MH unit employees). The table below shows the areas reviewed for this topic. The areas marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

NM	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.	• Ten of 13 patient care areas were not clean. • Public and/or staff restrooms in or adjacent to eight patient care areas were in need of cleaning. • The following maintenance issues were identified: o Damaged towel dispensers with sharp exposed pieces in 3 of the 13 patient care areas. o Damaged doors and/or doorframes in 7 of the 13 patient care areas. o Damaged floors and/or baseboards in 4 of the 13 patient care areas.
	Infection prevention requirements were met.	
	Medication safety and security requirements were met.	
	Auditory privacy requirements were met.	
	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.	

NM	Areas Reviewed for Radiology	Findings
	The facility had a Radiation Safety Committee, the committee met at least every 6 months and established a quorum for meetings, and the Radiation Safety Officer attended meetings.	
	Radiation Safety Committee meeting minutes reflected discussion of any problematic areas, corrective actions taken, and tracking of corrective actions to closure.	
	Facility policy addressed frequencies of equipment inspection, testing, and maintenance.	
	The facility had a policy for the safe use of fluoroscopic equipment.	
	The facility Director appointed a Radiation Safety Officer to direct the radiation safety program.	
	X-ray and fluoroscopy equipment items were tested by a qualified medical physicist before placed in service and annually thereafter, and quality control was conducted on fluoroscopy equipment in accordance with facility policy/procedure.	
	Designated employees received initial radiation safety training and training thereafter with the frequency required by local policy, and radiation exposure monitoring was completed for employees within the past year.	
	Environmental safety requirements in x-ray and fluoroscopy were met.	
	Infection prevention requirements in x-ray and fluoroscopy were met.	
	Medication safety and security requirements in x-ray and fluoroscopy were met.	
	Sensitive patient information in x-ray and fluoroscopy was protected.	
	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.	
	Areas Reviewed for Acute MH	
	MH EOC inspections were conducted every 6 months.	
	Corrective actions were taken for environmental hazards identified during inspections, and actions were tracked to closure.	

NM	Areas Reviewed for Acute MH (continued)	Findings
X	MH unit staff, MSIT members, and occasional unit workers received training on how to identify and correct environmental hazards, content and proper use of the MH EOC Checklist, and VA's National Center for Patient Safety study of suicide on psychiatric units.	• Five of the locked MH unit staff and four of the MSIT members had not completed the required training.
	Locked MH unit(s) were in compliance with MH EOC Checklist safety requirements or an abatement plan was in place.	
	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.	

Recommendations

6. We recommended that processes be strengthened to ensure that patient care areas and restrooms are clean and that compliance be monitored.

7. We recommended that processes be strengthened to ensure that damaged towel dispensers, doors and doorframes, and floors and baseboards are repaired and that ongoing maintenance be monitored.

8. We recommended that processes be strengthened to ensure that all locked MH unit staff and MSIT members receive training on how to identify and correct environmental hazards, proper use of the MH EOC Checklist, and VA's National Center for Patient Safety study of suicide on psychiatric units and that compliance be monitored.

Medication Management

The purpose of this review was to determine whether the appropriate clinical oversight and education were provided to patients discharged with orders for fluoroquinolone oral antibiotics.[3]

We reviewed relevant documents and conversed with key managers and employees. Additionally, we reviewed the EHRs of 32 randomly selected inpatients discharged on 1 of 3 selected oral antibiotics. 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.

NM	Areas Reviewed	Findings
	Clinicians conducted inpatient learning assessments within 24 hours of admission or earlier if required by local policy.	
	If learning barriers were identified as part of the learning assessment, medication counseling was adjusted to accommodate the barrier(s).	
	Patient renal function was considered in fluoroquinolone dosage and frequency.	
	Providers completed discharge progress notes or discharge instructions, written instructions were provided to patients/caregivers, and EHR documentation reflected that the instructions were understood.	
	Patients/caregivers were provided a written medication list at discharge, and the information was consistent with the dosage and frequency ordered.	
	Patients/caregivers were offered medication counseling, and this was documented in patient EHRs.	
	The facility established a process for patients/caregivers regarding whom to notify in the event of an adverse medication event.	
	The facility complied with any additional elements required by VHA or local policy.	

Coordination of Care

The purpose of this review was to evaluate discharge planning for patients with selected aftercare needs.[4]

We reviewed relevant documents and conversed with key employees. Additionally, we reviewed the EHRs of 34 randomly selected patients with specific diagnoses who were discharged from July 1, 2012, through June 30, 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.

NM	Areas Reviewed	Findings
	Patients' post-discharge needs were identified, and discharge planning addressed the identified needs.	
	Patients received the ordered aftercare services and/or items within the ordered/expected timeframe.	
	Patients' and/or caregivers' knowledge and learning abilities were assessed during the inpatient stay.	
	Clinicians provided discharge instructions to patients and/or caregivers and validated their understanding.	
	The facility complied with any additional elements required by VHA or local policy.	

Nurse Staffing

The purpose of this review was to determine whether the facility implemented the staffing methodology for nursing personnel and completed annual reassessments and to evaluate nurse staffing on three inpatient units (acute medical/surgical, long-term care, and MH).[5]

We reviewed facility and unit-based expert panel documents and 28 training files, and we conversed with key employees. Additionally, we reviewed the actual nursing hours per patient day for 3 randomly selected units—acute medical/surgical unit 4B, CLC unit 4D, and MH unit 6F—for 50 randomly selected days between October 1, 2012, and September 30, 2013. The table below shows the areas reviewed for this topic. The area marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

NM	Areas Reviewed	Findings
	The facility either implemented or reassessed a nurse staffing methodology within the expected timeframes.	
X	The facility expert panel followed the required processes and included the required members.	• The facility expert panel did not include evening and night supervisory staff, staff nurses and other nursing staff providing direct care, and nurse managers from the various areas of the facility.
	The unit-based expert panels followed the required processes and included the 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.	

Recommendation

9. We recommended that the annual staffing plan reassessment process ensures that the facility expert panel includes all required members.

Pressure Ulcer Prevention and Management

The purpose of this review was to determine whether acute care clinicians provided comprehensive pressure ulcer prevention and management.[6]

We reviewed relevant documents, 23 EHRs of patients with pressure ulcers (5 patients with hospital-acquired pressure ulcers, 10 patients with community-acquired pressure ulcers, and 8 patients with pressure ulcers at the time of our onsite visit), and 10 employee training records. Additionally, we inspected three patient rooms. The table below shows the areas reviewed for this topic. The area marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

NM	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 6 of the 23 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.	
	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.	

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

Recommendation

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

CLC Resident Independence and Dignity

The purpose of this review was to determine whether VHA facilities provided CLC restorative nursing services and complied with selected nutritional management and dining service requirements to assist CLC residents in maintaining their optimal level of functioning, independence, and dignity.[7]

We reviewed 16 EHRs of residents (10 residents receiving restorative nursing services and 6 residents not receiving restorative nursing services but candidates for services). We also observed 2 residents during 2 meal periods, reviewed 10 employee training/competency records and other relevant documents, and conversed with key employees. The table below shows the areas reviewed for this topic. The area marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

NM	Areas Reviewed	Findings
	The facility offered restorative nursing services.	
	Facility staff completed and documented restorative nursing services, including active and passive range of motion, bed mobility, transfer, and walking activities, according to clinician orders and residents' care plans.	
	Resident progress towards restorative nursing goals was documented, and interventions were modified as needed to promote the resident's accomplishment of goals.	
	When restorative nursing services were care planned but were not provided or were discontinued, reasons were documented in the EHR.	
	If residents were discharged from physical therapy, occupational therapy, or kinesiotherapy, there was hand-off communication between Physical Medicine and Rehabilitation Service and the CLC to ensure that restorative nursing services occurred.	
	Training and competency assessment were completed for staff who performed restorative nursing services.	
X	The facility complied with any additional elements required by VHA or local policy.	Facility policy on restorative nursing reviewed: • Eight of the applicable 10 residents' EHRs did not contain documentation of the facility's required initial weekly resident progress and revision of goals by the restorative coordinator.

NM	Areas Reviewed for Assistive Eating Devices and Dining Service	Findings
	Care planned/ordered assistive eating devices were provided to residents at meal times.	
	Required activities were performed during resident meal periods.	
	The facility complied with any additional elements required by VHA or local policy.	

Recommendation

11. We recommended that processes be strengthened to ensure that the restorative nursing initial weekly assessment is documented and that compliance be monitored.

Review Activity with Previous CAP Recommendations

Follow-Up on EOC Rounds Attendance

As a follow-up to a recommendation from our previous CAP review, we reassessed facility compliance with EOC rounds attendance.[8]

EOC Rounds. VHA requires that the Director or Associate Director lead weekly EOC rounds. Managers in nursing, building management, engineering, safety, patient safety, and infection control must be included as well as the Information Security Officer and others, as required. We reviewed EOC rounds documentation and determined that all required participants or their designees did not consistently participate in EOC rounds.

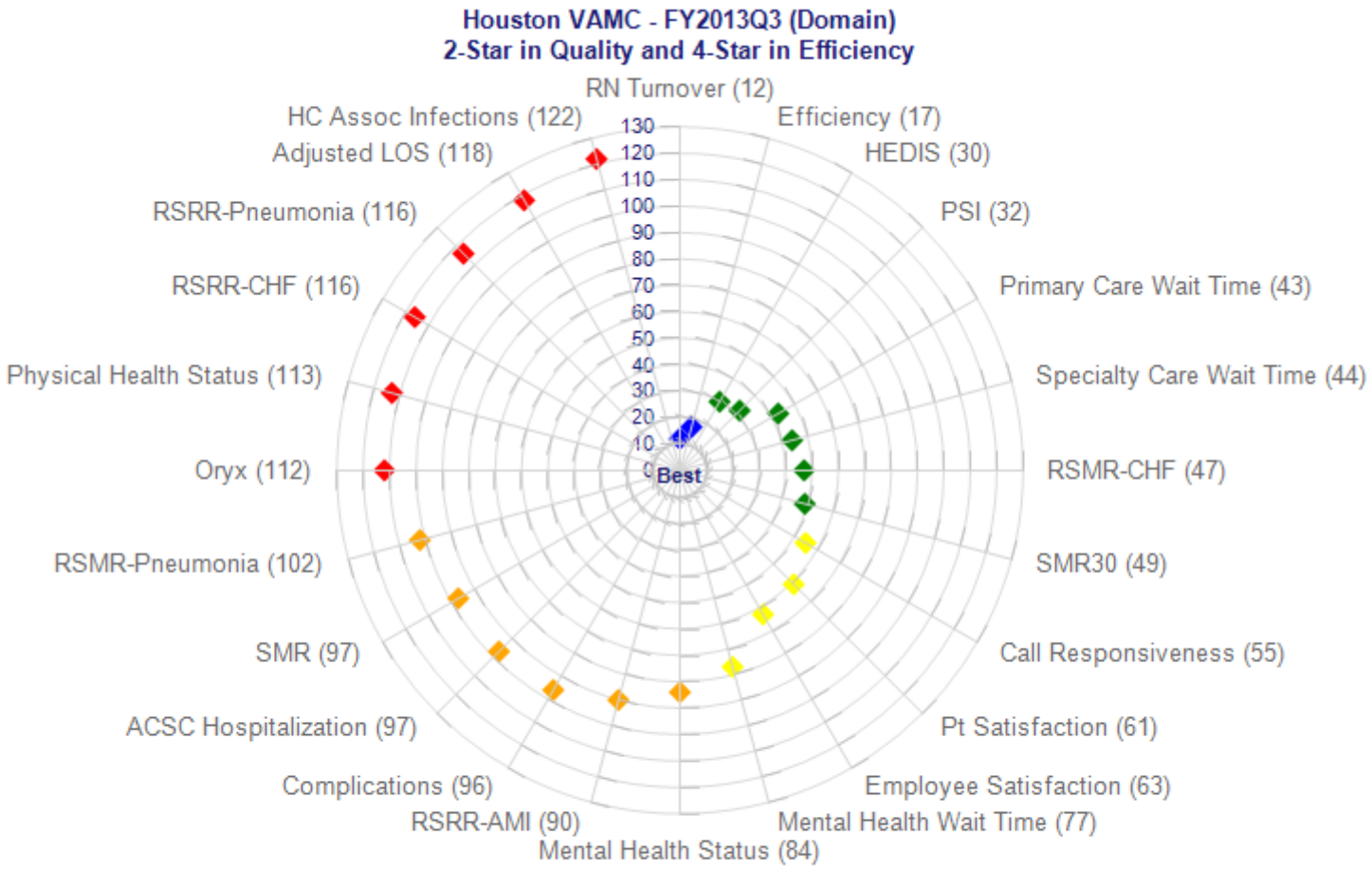
Recommendation

12. We recommended that processes be strengthened to ensure that all required participants or their designees consistently attend EOC rounds.

Facility Profile (Houston/580) FY 2014 through October 2013[a]	
Type of Organization	Tertiary
Complexity Level	1a-High complexity
Affiliated/Non-Affiliated	Affiliated
Total Medical Care Budget in Millions	$762.5
Number (as of November 2013) of:	
• **Unique Patients**	48,886
• **Outpatient Visits**	173,554
• **Unique Employees**[b]	3,805
Type and Number of Operating Beds:	
• **Hospital**	397
• **CLC**	141
• **MH**	40
Average Daily Census:	
• **Hospital**	306
• **CLC**	124
• **MH**	35
Number of Community Based Outpatient Clinics	7
Location(s)/Station Number(s)	Beaumont/580BY Charles Wilson/580BZ Galveston County/580GC Conroe/580GD Katy/580GE Lake Jackson/580GF Richmond/580GG
VISN Number	16

[a] All data is for FY 2014 through October 2013 except where noted.
[b] Unique employees involved in direct medical care (cost center 8200).

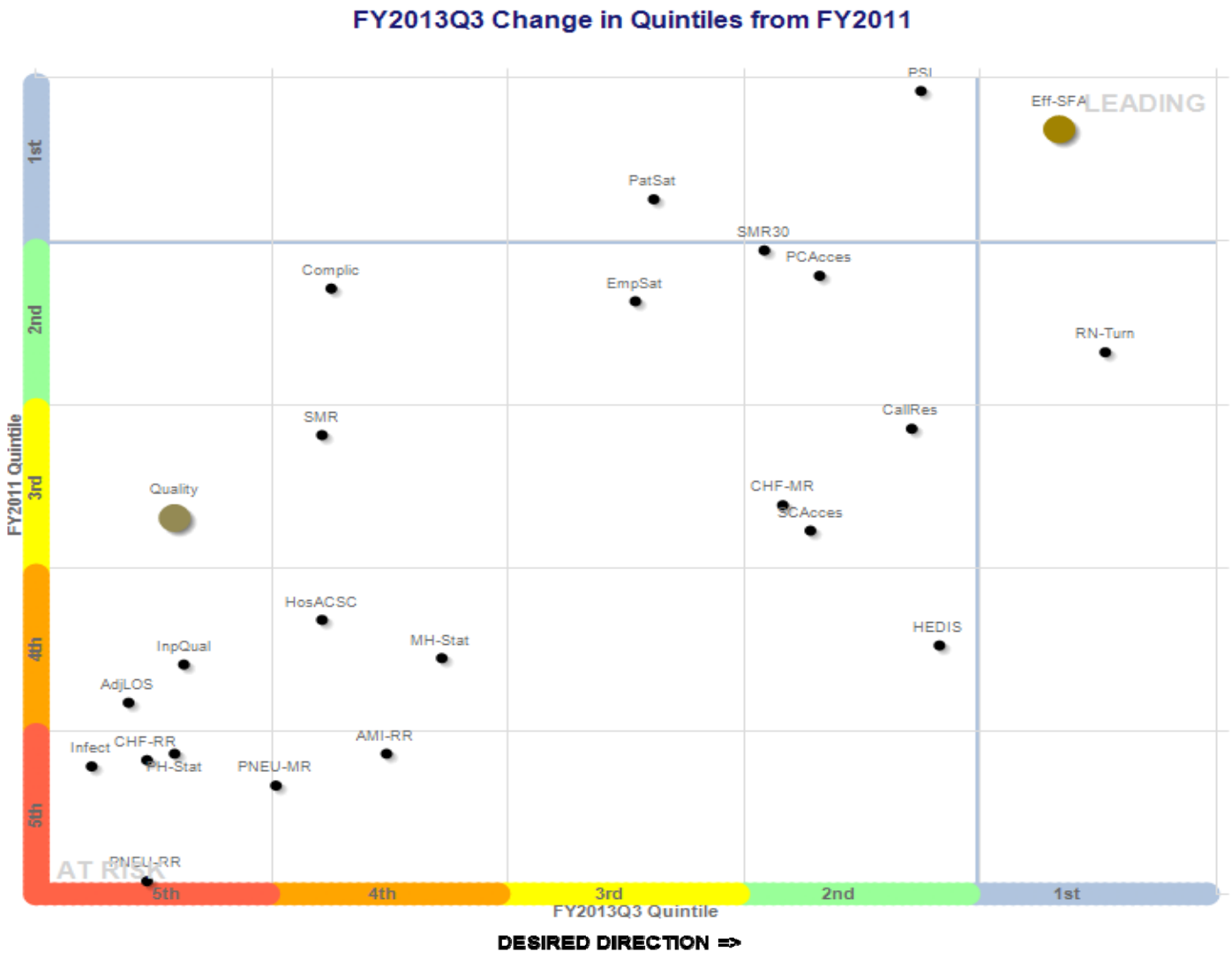
Strategic Analytics for Improvement and Learning (SAIL)[c]



Numbers in parentheses are facility ranking based on z-score of a metric among 128 facilities. Lower number is more favorable.
Marker color: Blue - 1st quintile; Green - 2nd; Yellow - 3rd; Orange - 4th; Red - 5th quintile.

[c] Metric definitions follow the graphs.

Scatter Chart



NOTE

Quintiles are derived from facility ranking on z-score of a metric among 128 facilities. Lower quintile is more favorable.

Metric Definitions

Measure	Definition	Desired direction
ACSC Hospitalization	Ambulatory care sensitive condition hospitalizations (observed to expected ratio)	A lower value is better than a higher value
Adjusted LOS	Acute care risk adjusted length of stay	A lower value is better than a higher value
Call Center Responsiveness	Average speed of call center responded to calls in seconds	A lower value is better than a higher value
Call Responsiveness	Call center speed in picking up calls and telephone abandonment rate	A lower value is better than a higher value
Complications	Acute care risk adjusted complication ratio	A lower value is better than a higher value
Efficiency	Overall efficiency measured as 1 divided by SFA (Stochastic Frontier Analysis)	A higher value is better than a lower value
Employee Satisfaction	Overall satisfaction with job	A higher value is better than a lower value
HC Assoc Infections	Health care associated infections	A lower value is better than a higher value
HEDIS	Outpatient performance measure (HEDIS)	A higher value is better than a lower value
MH Status	MH status (outpatient only, the Veterans RAND 12 Item Health Survey)	A higher value is better than a lower value
MH Wait Time	MH wait time for new and established patients (top 50 clinics)	A higher value is better than a lower value
Oryx	Inpatient performance measure (ORYX)	A higher value is better than a lower value
Physical Health Status	Physical health status (outpatient only, the Veterans RAND 12 item Health Survey)	A higher value is better than a lower value
Primary Care Wait Time	Primary care wait time for new and established patients (top 50 clinics)	A higher value is better than a lower value
PSI	Patient safety indicator	A lower value is better than a higher value
Pt Satisfaction	Overall rating of hospital stay (inpatient only)	A higher value is better than a lower value
RN Turnover	Registered nurse turnover rate	A lower value is better than a higher value
RSMR-AMI	30-day risk standardized mortality rate for acute myocardial infarction	A lower value is better than a higher value
RSMR-CHF	30-day risk standardized mortality rate for congestive heart failure	A lower value is better than a higher value
RSMR-Pneumonia	30-day risk standardized mortality rate for pneumonia	A lower value is better than a higher value
RSRR-AMI	30-day risk standardized readmission rate for acute myocardial infarction	A lower value is better than a higher value
RSRR-CHF	30-day risk standardized readmission rate for congestive heart failure	A lower value is better than a higher value
RSRR-Pneumonia	30-day risk standardized readmission rate for pneumonia	A lower value is better than a higher value
SMR	Acute care in-hospital standardized mortality ratio	A lower value is better than a higher value
SMR30	Acute care 30-day standardized mortality ratio	A lower value is better than a higher value
Specialty Care Wait Time	Specialty care wait time for new and established patients (top 50 clinics)	A higher value is better than a lower value

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: January 3, 2014

From: Director, South Central VA Health Care Network (10N16)

Subject: **CAP Review of the Michael E. DeBakey VA Medical Center, Houston, TX**

To: Director, Dallas Office of Healthcare Inspections (54DA)

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

1. The South Central VA Health Care Network (VISN 16) has reviewed and concurs with the draft Combined Assessment Program report for the Michael E. DeBakey VA Medical Center, Houston, TX.

2. If you have questions regarding the information submitted, please contact Reba T. Moore, VISN 16, Accreditation Specialist at (601) 206-7022.

Shannon Novotny, MPA, FACHE, Assistant Deputy Network Director

for and in the absence of:

Rica Lewis-Payton, MHA FACHE
Director, South Central VA Health Care Network (10N16)

Facility Director Comments

Department of Veterans Affairs **Memorandum**

Date: December 27, 2013

From: Director, Michael E. DeBakey VA Medical Center (580/00)

Subject: **CAP Review of the Michael E. DeBakey VA Medical Center, Houston, TX**

To: Director, South Central VA Health Care Network (10N16)

I have reviewed the report and concur with the recommendations. Action plans have been implemented to comply with the recommendations.

Adam C. Walmus, MHA, FACHE
Director, Michael E. DeBakey VA Medical Center (580/00)

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 the COS be appointed as the chairperson of the PRC.

Concur

Target date for completion: Completed December 13, 2013

Facility response: The Chief of Staff (COS) has been appointed as the chairperson of the Peer Review Committee. The Deputy COS will serve as the Acting COS in the absence of the COS.

Recommendation 2. We recommended that processes be strengthened to ensure that FPPEs for newly hired licensed independent practitioners are consistently initiated and that results are reported to the MEC.

Concur

Target date for completion: December 23, 2013

Facility response: A revised process of tracking FPPEs for newly hired providers through Credentialing and Privileging will be initiated. The process will involve tracking through to completion and reporting of results to the Clinical Executive Board.

Recommendation 3. We recommended that processes be strengthened to ensure that continued stay reviews are performed on at least 75 percent of patients in acute beds.

Concur

Target date for completion: June 1, 2014

Facility response: The UM Program will be restructured to achieve maximum efficiency and effectiveness. Plans are being initiated to increase the number of FTEEs allocated to the program to increase the number of continued stay reviews with the goal of reviewing at least 75 percent of patients in acute beds.

Recommendation 4. We recommended that the Operating Room Committee include the COS as a member.

Concur

Target date for completion: December 13, 2013

Facility response: The Chief of Staff has been added to the membership of the Operating Room Committee.

Recommendation 5. We recommended that processes be strengthened to ensure that the Blood Utilization Committee member from Surgery Service consistently attends meetings.

Concur

Target date for completion: January 31, 2014

Facility response: Expectations for consistent meeting attendance by required services has been communicated. Surgery Service, as well as all required services will be required to have a designated representative and an alternate to ensure consistent representation at each meeting of the Blood Utilization Committee.

Recommendation 6. We recommended that processes be strengthened to ensure that patient care areas and restrooms are clean and that compliance be monitored.

Concur

Target date for completion: January 31, 2014

Facility response: Although regular cleaning is conducted, materials used in original construction of the facility, e.g., floor tiles with white grout and plastic covered bases, present challenges in maintaining an aesthetic appearance. Planned renovation projects include a comprehensive redesign of the amenities to address these issues. In addition to daily cleaning, we have initiated a process to ensure detailed cleaning on an ongoing basis. Compliance will be monitored through Environment of Care and supervisory rounds. Additionally, Environmental Management Service is being realigned to report directly to the Deputy Medical Center Director for increased oversight in ensuring that cleanliness remains a major focus for the medical center.

Recommendation 7. We recommended that processes be strengthened to ensure that damaged towel dispensers, doors and doorframes, and floors and baseboards are repaired and that ongoing maintenance be monitored.

Concur

Target date for completion: January 31, 2014

Facility response: A general maintenance schedule has been developed. Plans have been initiated to increase facility maintenance staff to adequately address ongoing structural needs. An in-house construction team will be assigned to implement the general maintenance schedule to ensure compliance with addressing ongoing maintenance needs. Quarterly monitoring will be conducted.

Recommendation 8. We recommended that processes be strengthened to ensure that all locked MH unit staff and MSIT members receive training on how to identify and correct environmental hazards, proper use of the MH EOC Checklist, and VA's National Center for Patient Safety study of suicide on psychiatric units and that compliance be monitored.

Concur

Target date for completion: January 15, 2014

Facility response: All mental health unit staff has been assigned the Mental Health Environment of Care training and VA's National Center for Patient Safety study of suicide on psychiatric units in VA Talent Management System (TMS) to be completed on an annual basis. All members of the Mental Health Safety Inspection Team will also be assigned to complete this training in TMS. Monthly monitoring of training completion will be conducted.

Recommendation 9. We recommended that the annual staffing plan reassessment process ensures that the facility expert panel includes all required members.

Concur

Target date for completion: Completed November 30, 2013

Facility response: The facility expert panel has been updated to include all required members. The panel includes evening and night supervisory staff, staff nurses and other nursing staff providing direct care, and nurse managers from the various areas of the facility.

Recommendation 10. We recommended that processes be strengthened to ensure that acute care staff accurately document location, stage, risk scale score, and date pressure ulcer acquired for all patients with pressure ulcers and that compliance be monitored.

Concur

Target date for completion: Completed November 30, 2013

Facility response: Skin Risk Management Team, in conjunction with the simulation lab and skills fair has re-educated staff on the Braden Scale and appropriate documentation. Nurse Executives and Nurse Managers have initiated monthly monitoring for compliance.

Recommendation 11. We recommended that processes be strengthened to ensure that the restorative nursing initial weekly assessment is documented and that compliance be monitored.

Concur

Target date for completion: Completed December 6, 2013

Facility response: The Restorative Coordinator documents the initial assessment within the first 7 days of initial evaluation. Goals are revised as appropriate for each resident on the program. Monthly record reviews will be conducted to ensure compliance.

Recommendation 12. We recommended that processes be strengthened to ensure that all required participants or their designees consistently attend EOC rounds.

Concur

Target date for completion: November 30, 2013

Facility response: Expectations for consistent participation in EOC rounds by all required participants has been communicated. Additionally, the rounds have been modified to facilitate consistent participation by required staff. Monthly monitoring will be conducted.

OIG Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the OIG at (202) 461-4720.
Onsite Contributors	Trina Rollins, MS, PA-C, Team Leader Gayle Karamanos, MS, PA-C Cathleen King, MHA, CRRN Larry Ross, MS James Werner, Special Agent In Charge, Office of Investigations
Other Contributors	Elizabeth Bullock Shirley Carlile, BA Paula Chapman, CTRS Lin Clegg, PhD Marnette Dhooghe, MS Matt Frazier, MPH Jeff Joppie, BS Misti Kincaid, BS Victor Rhee, MHS Julie Watrous, RN, MS Jarvis Yu, MS

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Endnotes

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