Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 13-03626-73

Combined Assessment Program Review of the James E. Van Zandt VA Medical Center Altoona, Pennsylvania

February 14, 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
EHR	electronic health record
EOC	environment of care
facility	James E. Van Zandt VA Medical Center
FY	fiscal year
MEC	Medical Executive Committee
MH	mental health
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

Table of Contents

	Page
Executive Summary	i
Objectives and Scope	1
Objectives	1
Scope	1
Reported Accomplishment	2
Results and Recommendations	3
QM	3
EOC	6
Medication Management	9
Coordination of Care	10
Nurse Staffing	11
Pressure Ulcer Prevention and Management	12
CLC Resident Independence and Dignity	14
Appendixes	
A. Facility Profile	16
B. Strategic Analytics for Improvement and Learning	17
C. Acting VISN Director Comments	20
D. Facility Director Comments	21
E. OIG Contact and Staff Acknowledgments	26
F. Report Distribution	27
G. Endnotes	28

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 October 21, 2013.

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

- Coordination of Care
- Nurse Staffing

The facility's reported accomplishment was the establishment of the Veterans Justice Outreach Program.

Recommendations: We made recommendations in the following five activities:

Quality Management: Ensure the Peer Review Committee consistently submits quarterly summary reports to the Clinical Management Committee.

Environment of Care: Secure soiled utility rooms and unattended construction sites. Educate canteen/cafeteria employees on hand hygiene requirements. Ensure all designated x-ray and fluoroscopy employees receive annual radiation safety training. Conduct and document daily automated external defibrillator checks.

Medication Management: Ensure clinicians conducting medication education accommodate identified learning barriers and document the accommodations made to address those barriers.

Pressure Ulcer Prevention and Management: Establish an interprofessional pressure ulcer committee. Provide and document pressure ulcer education for patients at risk for and with pressure ulcers and/or their caregivers.

Community Living Center Resident Independence and Dignity: Ensure employees who perform restorative nursing services receive training on and competency assessment for range of motion and resident transfers.

Comments

The Acting Veterans Integrated Service Network Director and Facility Director agreed with the Combined Assessment Program review findings and recommendations and

provided acceptable improvement plans. (See Appendixes C and D, pages 20–25, 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
- Coordination of Care
- Nurse Staffing
- Pressure Ulcer Prevention and Management
- CLC Resident Independence and Dignity

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 2013 and FY 2014 through October 21, 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 E. Van Zandt VA Medical Center, Altoona, Pennsylvania,* Report No. 09-01732-10, October 16, 2009). We made a repeat recommendation in EOC.

During this review, we presented crime awareness briefings for 207 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 104 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 Accomplishment

Veterans Justice Outreach Program

The facility successfully established VA presence in veterans' courts in Centre and Cambria counties through the Veterans Justice Outreach Program. This program helps avoid unnecessary criminalization of veterans with mental illness and extended incarceration by ensuring that eligible justice-involved veterans have timely access to VA medical services as clinically indicated. In FY 2013, facility staff visited the Centre County jail in Bellefonte to enroll veterans into treatment when possible. Facility staff have also reached out to criminal justice advisory boards, local government groups, and legal systems to provide information about the Veterans Justice Outreach Initiative.

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 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
	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 Chief of Staff 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.	Twelve months of Clinical Management Committee meeting minutes reviewed: • Only two quarterly summary reports were documented as received by the Clinical Management Committee.
	Focused Professional Practice Evaluations for newly hired licensed independent practitioners were initiated, completed, and reported to the MEC.	
	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.	
	Staff performed continuing stay reviews on at least 75 percent of patients in acute beds.	
	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.	
NA	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.	
NA	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
	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.	
	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.	

Recommendation

1. We recommended that the PRC consistently submit quarterly summary reports to the Clinical Management Committee.

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 the medicine, the intensive care, and two CLC units; the emergency department; the outpatient behavioral health clinic; the dental clinic; the laboratory; and radiology. Additionally, we reviewed relevant documents, conversed with key employees and managers, and reviewed five radiology employee training records. 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.	• Soiled utility rooms were not secured in the four inpatient care areas inspected. This was a repeat finding from the previous CAP review. • Two patient care area construction sites were unattended and unsecured.
X	Infection prevention requirements were met.	• In the canteen/cafeteria area, employees were observed not washing their hands after working at a cash register and then returning to prepare food.
	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.	
	Areas Reviewed for Radiology	
	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.	

NM	Areas Reviewed for Radiology (continued)	Findings
	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.	
X	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.	• None of the five x-ray and fluoroscopy employees with ≥2 years of employment had documentation of radiation safety training.
	Environmental safety requirements in x-ray and fluoroscopy were met.	
	Infection prevention requirements in x-ray and fluoroscopy were met.	
X	Medication safety and security requirements in x-ray and fluoroscopy were met.	Local policy for crash cart/automated external defibrillator checks reviewed: • No automated external defibrillator testing had been documented since July 2013.
	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	
NA	MH EOC inspections were conducted every 6 months.	
NA	Corrective actions were taken for environmental hazards identified during inspections, and actions were tracked to closure.	

NM	Areas Reviewed for Acute MH (continued)	Findings
NA	MH unit staff, Multidisciplinary Safety Inspection Team 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.	
NA	The locked MH unit(s) was/were in compliance with MH EOC Checklist safety requirements or an abatement plan was in place.	
NA	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.	

Recommendations

2. We recommended that processes be strengthened to ensure that soiled utility rooms are secured and that compliance be monitored.

3. We recommended that processes be strengthened to ensure that construction sites are secured when unattended and that compliance be monitored.

4. We recommended that canteen/cafeteria employees be educated on hand hygiene requirements and that compliance be monitored.

5. We recommended that processes be strengthened to ensure that all designated x-ray and fluoroscopy employees receive annual radiation safety training.

6. We recommended that processes be strengthened to ensure that automated external defibrillator checks are conducted daily and documented 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 35 randomly selected inpatients discharged on 1 of 3 selected oral antibiotics. 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
	Clinicians conducted inpatient learning assessments within 24 hours of admission or earlier if required by local policy.	
X	If learning barriers were identified as part of the learning assessment, medication counseling was adjusted to accommodate the barrier(s).	• For the 17 patients with identified learning barriers, EHR documentation did not reflect medication counseling accommodation to address the barriers.
	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.	

Recommendation

7. We recommended that processes be strengthened to ensure that clinicians conducting medication education accommodate identified learning barriers and document the accommodations made to address those barriers and that compliance be monitored.

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 14 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.	
	Clinicians provided discharge instructions to patients and/or caregivers and validated their understanding.	
	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.	
	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 two inpatient units (acute medical/surgical and long-term care).[5]

We reviewed facility and unit-based expert panel documents and seven training files, and we conversed with key employees. Additionally, we reviewed the actual nursing hours per patient day for 2 randomly selected units—acute medical/surgical unit 4 Medical and the CLC—for 50 randomly selected days between October 1, 2012, and September 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
	The facility either implemented or reassessed a nurse staffing methodology within the expected timeframes.	
	The facility expert panel followed the required processes and included the required members.	
	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.	

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, 11 EHRs of patients with pressure ulcers (1 patient with hospital-acquired pressure ulcers and 10 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 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.	
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.
	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.	
	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 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.	
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.	Facility pressure ulcer patient and caregiver education requirements reviewed: • None of the 11 EHRs contained evidence that education was provided.

NM	Areas Reviewed (continued)	Findings
	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.	
NA	The facility complied with selected fire and environmental safety, infection prevention, and medication safety and security requirements in pressure ulcer patient rooms.	
	The facility complied with any additional elements required by VHA or local policy.	

Recommendations

8. We recommended that the facility establish an interprofessional pressure ulcer committee.

9. We recommended that processes be strengthened to ensure that acute care staff provide and document pressure ulcer education for patients at risk for and with pressure ulcers and/or their caregivers 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 10 EHRs of residents (5 residents receiving restorative nursing services and 5 residents not receiving restorative nursing services but candidates for services). We also observed nine residents during two meal periods, reviewed five 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.	
X	Training and competency assessment were completed for staff who performed restorative nursing services.	• Two employee training records did not contain evidence of training in resident transfers. • None of the records contained evidence of training in range of motion. • None of the records contained evidence of competency assessment for range of motion and resident transfers.
	The facility complied with any additional elements required by VHA or local policy.	

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.	

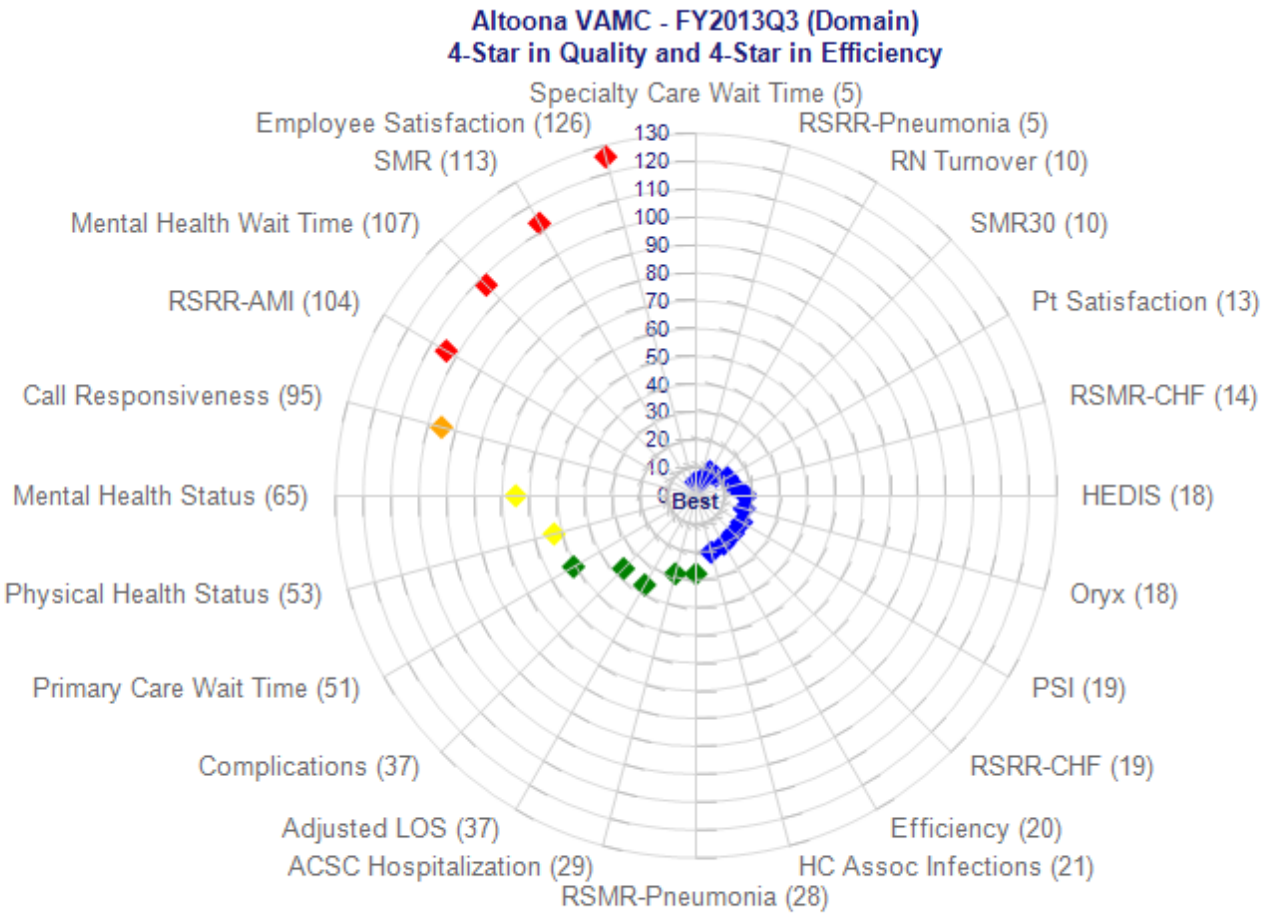
Recommendation

10. We recommended that processes be strengthened to ensure that employees who perform restorative nursing services receive training on and competency assessment for range of motion and resident transfers.

Facility Profile (Altoona/503) FY 2014 through October 2013	
Type of Organization	Secondary
Complexity Level	3-Low complexity
Affiliated/Non-Affiliated	Non-Affiliated
Total Medical Care Budget in Millions	$108.3
Number of:	
• **Unique Patients**	24,816
• **Outpatient Visits**	213,442
• **Unique Employees**[a]	472
Type and Number of Operating Beds:	
• **Hospital**	28
• **CLC**	40
• **MH**	N/A
Average Daily Census:	
• **Hospital**	8
• **CLC**	35
• **MH**	N/A
Number of Community Based Outpatient Clinics	3
Location(s)/Station Number(s)	Johnstown/503GA DuBois/503GB State College/503GC
VISN Number	4

[a] Unique employees involved in direct medical care (cost center 8200) from most recent pay period.

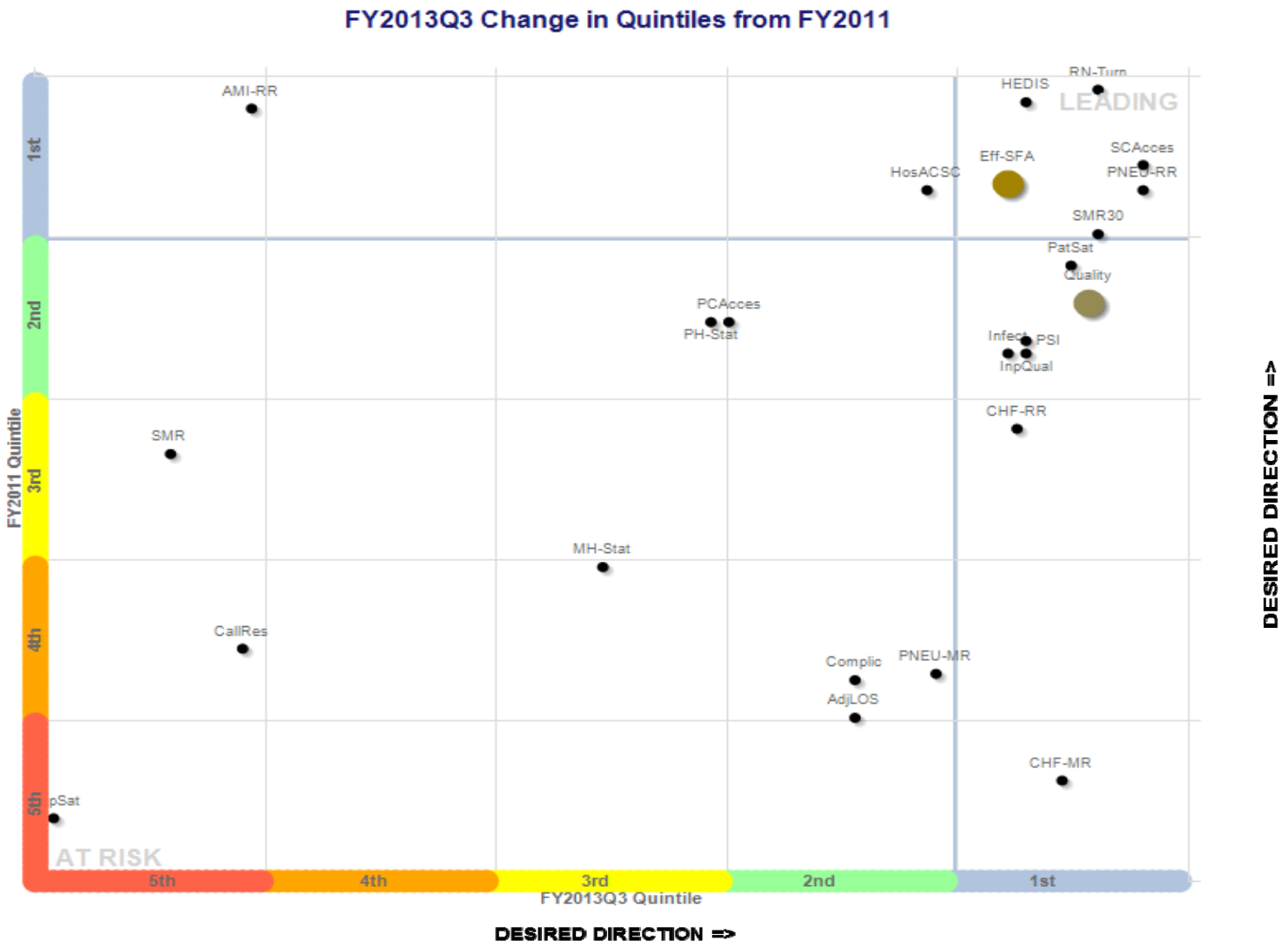
Strategic Analytics for Improvement and Learning (SAIL)[b]



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.

[b] 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

Acting VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: January 17, 2014

From: Director, VA Healthcare (10N4)

Subject: **CAP Review of the James E. Van Zandt VA Medical Center, Altoona, PA**

To: Director, Washington, DC, Office of Healthcare Inspections (54DC)

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

1. I have reviewed the document and concur with the recommendations. Corrective action plans have been established with planned completion dates, as detailed in the attached report.

2. If you have any questions or concerns, please contact Barbara Forsha, VISN 4 Quality Management Officer at 412-822-3290.

(original signed by:)
Gary W. Devansky
Acting VISN 4 Network Director

Facility Director Comments

Department of Veterans Affairs **Memorandum**

Date: January 17, 2014

From: Director, James E. Van Zandt VA Medical Center (503/00)

Subject: **CAP Review of the James E. Van Zandt VA Medical Center, Altoona, PA**

To: Director, VA Healthcare (10N4)

1. I have reviewed and concur with the findings and recommendations in draft report of the Office of the Inspector General Combined Assessment Program Review conducted the week of October 21, 2013.

2. Corrective actions plans have been established with target completion dates, as detailed in the attached report.

(original signed by:)
William H. Mills
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 the PRC consistently submit quarterly summary reports to the Clinical Management Committee.

Concur

Target date for completion: June 30, 2014

Facility response: The Clinical Management Committee (CMC) tracking spreadsheet has been updated by the Chief of Staff to reflect that Peer Review Committee reports (to include graphs) are presented to the CMC quarterly (March, June, September, December). To become current on the reports, second quarter peer review data was reviewed at the November CMC meeting. Third quarter data was reviewed at the December CMC meeting and is now current with the quarterly reporting. Peer review data will continue to be reviewed at CMC quarterly as per the quarterly schedule. Minutes from the CMC will be monitored by the Chief of Staff to ensure the minutes reflect that these reports have been discussed at the required frequency. Monitoring will continue through June 2014 to show compliance is sustained.

Recommendation 2. We recommended that processes be strengthened to ensure that soiled utility rooms are secured and that compliance be monitored.

Concur

Target date for completion: April 15, 2014

Facility response: Soiled utility room locks were ordered in December. Within two weeks of receipt, the Chief Facilities Service will ensure that the locks will be installed and that the staff will be educated on the use of the locks. The locks are self-locking therefore the doors are always locked.

Recommendation 3. We recommended that processes be strengthened to ensure that construction sites are secured when unattended and that compliance be monitored.

Concur

Target date for completion: April 30, 2014

Facility response: The Associate Director received confirmation from contracting that construction contracts require that unattended construction sites will be secured. The construction Contracting Officer Representatives (CORs) were re-educated on

January 15, 2014, and monitoring began January 15, 2014. Monitoring will be reported by CORs to the Construction Safety Sub-Committee starting in February 2014 until documentation of three consecutive months of compliance is achieved.

Recommendation 4. We recommended that canteen/cafeteria employees be educated on hand hygiene requirements and that compliance be monitored.

Concur

Target date for completion: March 31, 2014

Facility response: The Chief, Canteen Service re-educated the canteen staff on hand washing/hand hygiene. Starting in January 2014, the Chief, Nutrition and Food Service will monitor compliance monthly and report compliance data to the Infection Control Committee and the Associate Director until documentation of three consecutive months of compliance is achieved.

Recommendation 5. We recommended that processes be strengthened to ensure that all designated x-ray and fluoroscopy employees receive annual radiation safety training.

Concur

Target date for completion: Completed November 13, 2013

Facility response: All radiology technologists have completed radiation safety courses in Talent Management System (TMS). Additionally, the National Radiology Program Office distributed a course for fluoroscopy training which was read by all technologists and documented at the November 13, 2013 staff meeting. Annually, the radiology supervisor will assign TMS (radiation safety) courses to the technologists. The 1st quarter of each year, the MRI and Radiation Safety Committee will evaluate annual radiation and fluoroscopy training requirements and report findings to the Radiation Safety Officer.

Recommendation 6. We recommended that processes be strengthened to ensure that automated external defibrillator checks are conducted daily and documented and that compliance be monitored.

Concur

Target date for completion: March 31, 2014

Facility response: The radiology supervisor provided education to the technologists on proper defibrillator checks at the radiology staff meeting of November 13, 2013. The MRI crash cart is checked daily by the MRI technologists at the beginning of each shift. The CT and general crash cart is also checked daily at the beginning of each shift by an assigned technologist. Crash cart checks now include running external defibrillator strips. Crash cart check monitoring is now a standard topic on the radiology staff meeting agenda and reported quarterly at the radiology staff meeting.

Recommendation 7. We recommended that processes be strengthened to ensure that clinicians conducting medication education accommodate identified learning barriers and document the accommodations made to address those barriers and that compliance be monitored.

Concur

Target date for completion: March 31, 2014

Facility response: The Associate Director for Patient Care/Nursing Service enhanced the discharge instruction template to reflect that the communication needs has been addressed. The Associate Director for Patient Care/Nursing Service will be monitoring 100 percent of discharge instructions for documentation that reflects the component of communication needs assessment has been completed until three consecutive months of compliance is achieved beginning in January 2014. The benchmark/threshold for compliance will be 90 percent.

Recommendation 8. We recommended that the facility establish an interprofessional pressure ulcer committee.

Concur

Target date for completion: June 30, 2014

Facility response: The Associate Director for Patient Care/Nursing Service established an interprofessional pressure ulcer committee which includes the Community Living Center Registered Nurse Assessment Coordinator (Chairperson), Certified Wound Care Specialist, Nurse Educator, Outpatient Service Registered Nurse, Clincial Dietitian, Pharmacist, and Supervisor Physical Medicine and Rehabilitiation. The committee will meet quarterly. The first meeting for the interprofessional pressure ulcer committee was January 16, 2014. The minutes from this meeting are forwarded to the Patient Care Services Management Council and will be included in the reports submitted to the Clinical Management Committee on a quarterly basis. The Associate Director for Patient Care/Nursing Service will monitor compliance until 2 quarters of compliance is achieved starting January 2014.

Recommendation 9. We recommended that processes be strengthened to ensure that acute care staff provide and document pressure ulcer education for patients at risk for and with pressure ulcers and/or their caregivers and that compliance be monitored.

Concur

Target date for completion: March 31, 2014

Facility response: The Associate Director for Patient Care/Nursing Service will ensure that the patient's plan of care reflects pressure ulcer education was provided for the patient/caregiver. Pressure ulcer education will be reflective in the plan of care – as the problem/planning is identified, interventions are completed and the evaluation of the

problem is done. In addition, a drop down box for pressure ulcer education was added to the discharge instruction template. The Associate Director for Patient Care/Nursing Service will be monitoring 100 percent of care plans until three consecutive months of compliance is achieved beginning in January 2014. The Associate Director for Patient Care/Nursing Service will be monitoring 100 percent of discharge notes of patients/residents with pressure ulcers until three consecutive months of compliance is achieved beginning in January 2014. The benchmark/threshold for compliance will be 90 percent.

Recommendation 10. We recommended that processes be strengthened to ensure that employees who perform restorative nursing services receive training on and competency assessment for range of motion and resident transfers.

Concur

Target date for completion: January 31, 2014

Facility response: The Associate Director for Patient Care/Nursing Service has developed and distributed educational training plans to all staff for the training needed (range of motion and resident transfers), and staff is in the process of completing the needed training. As part of the training, the staff member will have the checklist completed which will validate the competency for each individual with completion of January 31, 2014 as so noted for the training. The Associate Director for Patient Care/Nursing Service has developed a process for continued training and competencies to be completed for new Community Living Center staff through new employee orientation. The Associate Director for Patient Care/Nursing Service will monitor weekly staff compliance with completion of the training and competency assessments until 100% of staff have successfully completed the training and competency checklist.

OIG Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the OIG at (202) 461-4720.
Onsite Contributors	Lisa Barnes, MSW, Team Leader Gail Bozzelli, RN Myra Conway, RN, MS Kay Foster, RN Donna Giroux, RN Randall Snow, JD Thomas Dominski, Special Agent, Office of Investigations
Other Contributors	Bruce Barnes Elizabeth Bullock Shirley Carlile, BA Paula Chapman, CTRS Lin Clegg, PhD Marnette Dhooghe, MS Matt Frazier, MPH Jeff Joppie, BS Victor Rhee, MHS Natalie Sadow, MBA Julie Watrous, RN, MS Jarvis Yu, MS

Report Distribution

VA Distribution

Office of the Secretary
VHA
Assistant Secretaries
General Counsel
Acting Director, VA Healthcare (10N4)
Director, James E. Van Zandt VA Medical Center (503/00)

Non-VA Distribution

House Committee on Veterans' Affairs
House Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
House Committee on Oversight and Government Reform
Senate Committee on Veterans' Affairs
Senate Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
Senate Committee on Homeland Security and Governmental Affairs
National Veterans Service Organizations
Government Accountability Office
Office of Management and Budget
U.S. Senate: Robert P. Casey, Jr.; Patrick J. Toomey
U.S. House of Representatives: Keith Rothfus, Bill Shuster, Glenn W. Thompson

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*, October 15, 2012.
- 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.

[2] References used for this topic included:
- VHA Directive 1105.01, *Management of Radioactive Materials*, October 7, 2009.
- VHA Directive 2011-007, *Required Hand Hygiene Practices*, February 16, 2011.
- VHA Handbook 1105.04, *Fluoroscopy Safety*, July 6, 2012.
- VHA Handbook 1160.01, *Uniform Mental Health Services in VA Medical Centers and Clinics*, September 11, 2008.
- VA Radiology, "Online Guide," http://vaww1.va.gov/RADIOLOGY/OnLine_Guide.asp, updated October 4, 2011.
- VA National Center for Patient Safety, "Privacy Curtains and Privacy Curtain Support Structures (e.g., Track and Track Supports) in Locked Mental Health Units," Patient Safety Alert 07-04, February 16, 2007.
- VA National Center for Patient Safety, "Multi-Dose Pen Injectors," Patient Safety Alert 13-04, January 17, 2013.
- VA National Center for Patient Safety, *Mental Health Environment of Care Checklist (MHEOCC)*, April 11, 2013.
- Deputy Under Secretary for Health for Operations and Management, "Mitigation of Items Identified on the Environment of Care Checklist," November 21, 2008.
- Deputy Under Secretary for Health for Operations and Management, "Change in Frequency of Review Using the Mental Health Environment of Care Checklist," April 14, 2010.
- Deputy Under Secretary for Health for Operations and Management, "Guidance on Locking Patient Rooms on Inpatient Mental Health Units Treating Suicidal Patients," October 29, 2010.
- Various requirements of The Joint Commission, the Occupational Safety and Health Administration, the National Fire Protection Association, the Health Insurance Portability and Accountability Act, the American College of Radiology Practice Guidelines and Technical Standards, Underwriters Laboratories.

[3] References used for this topic included:
- VHA Handbook 1108.06, *Inpatient Pharmacy Services*, June 27, 2006.
- VHA Handbook 1108.05, *Outpatient Pharmacy Services*, May 30, 2006.
- VHA Directive 2011-012, *Medication Reconciliation*, March 9, 2011.
- VHA Handbook 1907.01.
- Manufacturer's instructions for Cipro® and Levaquin®.
- Various requirements of The Joint Commission.

[4] References used for this topic included:
- VHA Handbook 1120.04, *Veterans Health Education and Information Core Program Requirements*, July 29, 2009.
- VHA Handbook 1907.01.
- The Joint Commission, *Comprehensive Accreditation Manual for Hospitals*, July 2013.

[5] The references used for this topic were:
- VHA Directive 2010-034, *Staffing Methodology for VHA Nursing Personnel*, July 19, 2010.
- VHA "Staffing Methodology for Nursing Personnel," August 30, 2011.

[6] References used for this topic included:
- VHA Handbook 1180.02, *Prevention of Pressure Ulcers*, July 1, 2011 (corrected copy).
- Various requirements of The Joint Commission.
- Agency for Healthcare Research and Quality Guidelines.
- National Pressure Ulcer Advisory Panel Guidelines.
- The New York State Department of Health, et al., *Gold STAMP Program Pressure Ulcer Resource Guide*, November 2012.

[7] References used for this topic included:
- VHA Handbook 1142.01, *Criteria and Standards for VA Community Living Centers (CLC)*, August 13, 2008.
- VHA Handbook 1142.03, *Requirements for Use of the Resident Assessment Instrument (RAI) Minimum Data Set (MDS)*, January 4, 2013.
- Centers for Medicare and Medicaid Services, *Long-Term Care Facility Resident Assessment Instrument User's Manual*, Version 3.0, May 2013.
- VHA Manual M-2, Part VIII, Chapter 1, *Physical Medicine and Rehabilitation Service*, October 7, 1992.
- Various requirements of The Joint Commission.