Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 13-03652-59

Combined Assessment Program Review of the Lexington VA Medical Center Lexington, Kentucky

February 3, 2014

Washington, DC 20420

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

Glossary

CAP	Combined Assessment Program
CLC	community living center
COC	coordination of care
CRC	Cardiopulmonary Resuscitation Committee
EHR	electronic health record
EOC	environment of care
facility	Lexington VA Medical Center
FY	fiscal year
MEC	Medical Executive Committee
MH	mental health
MM	medication management
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 December 2, 2013.

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

- Medication Management
- Coordination of Care
- Nurse Staffing
- Pressure Ulcer Prevention and Management
- Community Living Center Resident Independence and Dignity

The facility's reported accomplishment was increasing the availability and timeliness of scanned documents in the electronic health record.

Recommendations: We made recommendations in the following two activities:

Quality Management: Ensure that all surgical deaths are reviewed by the facility's Surgical Committee and that the critical incident tracking and notification system's recipient list is current. Require the Transfusion and Tissue Review Committee member from Anesthesia Service to consistently attend meetings. Ensure the Cardiopulmonary Resuscitation Committee meets monthly and includes physician participation.

Environment of Care: Ensure that Environment of Care Committee minutes reflect deficiencies identified on the locked mental health unit and that tracking data reflect risk levels and tracking of actions to closure. Require that access to emergency exits at the Cooper division is unrestricted. Secure chemicals stored on the hemodialysis unit. Ensure Multidisciplinary Safety Inspection Team members and occasional locked mental health unit workers receive required training. Routinely test all panic alarms on the locked mental health unit, and properly secure all audiovisual equipment on the unit.

Comments

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

acceptable improvement plans. (See Appendixes C and D, pages 20–25, for the full text of the Directors' comments.) We will follow up on the planned actions until they are completed.

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

Objectives and Scope

Objectives

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

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

Scope

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
- MM
- COC
- 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 December 2, 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 Lexington VA Medical Center, Lexington, Kentucky,* Report No. 11-02078-290, September 27, 2011.)

During this review, we presented crime awareness briefings for 286 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 234 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

Increasing Availability of Scanned Documents

In June 2012, a Lean project[a] was chartered to address the backlog of documents pending scanning in the Health Benefits Center and to reduce the time for important documents to be available for viewing in veterans' EHRs. Barriers included lack of equipment and limited staffing. Multi-functional devices (print, scan, copy, and fax) were provided to each Health Benefits Advisor to scan documents on the spot. Additionally, a temporary employee was converted to full-time to eliminate the existing backlog. As a result, the facility was able to eliminate all backlog, reduce cycle times for enrollments from 48 minutes to 32 minutes, and upload documents the same day.

[a] Lean is a problem solving approach of delivering more value with less waste.

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.	
	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.	
	Focused Professional Practice Evaluations for newly hired licensed independent practitioners were initiated, completed, and reported to the MEC.	
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.	
	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.	
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.	Several surgical deaths occurred from January through July 2013: • There was no evidence that any of the deaths were reviewed by the facility's Surgical Committee.
X	Critical incidents reporting processes were appropriate.	• The recipient list for the automatic e-mail notification was not current.
	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 Transfusion and Tissue Review Committee meeting minutes reviewed: • The clinical representative from Anesthesia 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.	
X	The facility met any additional elements required by VHA or local policy.	Local policy on the CRC reviewed: • In FY 2013, the CRC lacked physician participation and did not consistently meet monthly.

Recommendations

1. We recommended that processes be strengthened to ensure that all surgical deaths are reviewed by the facility's Surgical Committee.

2. We recommended that processes be strengthened to ensure that the critical incident tracking and notification system's recipient list is current.

3. We recommended that that processes be strengthened to ensure that the Transfusion and Tissue Review Committee member from Anesthesia Service consistently attends meetings.

4. We recommended that that processes be strengthened to ensure that the CRC meets monthly and includes physician participation.

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]

At the Cooper division, we inspected the medical/surgical/telemetry, medical/surgical/palliative care, surgical intensive care, hemodialysis, and locked MH units. We also inspected the emergency department, the radiology area, and the chemotherapy and urology clinics. At the Leestown division, we inspected the outpatient general medicine, podiatry, MH, substance abuse, and women's health clinics. We also inspected the radiology area and two CLC areas. Additionally, we reviewed relevant documents, conversed with key employees and managers, and reviewed 33 employee-training records (11 radiology employees, 11 acute MH unit employees, 6 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
X	EOC Committee minutes reflected sufficient detail regarding identified deficiencies, corrective actions taken, and tracking of corrective actions to closure.	Six months of EOC Committee meeting minutes reviewed: • Minutes did not reflect discussion of deficiencies identified on the locked MH unit.
	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.	
X	Fire safety requirements were met.	• Equipment obstructed two of the nine emergency exits inspected at the Cooper division.
X	Environmental safety requirements were met.	• Six carts on the hemodialysis unit had unsecured dialysis chemicals.
	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.	
	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.	
	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.	
X	Corrective actions were taken for environmental hazards identified during inspections, and actions were tracked to closure.	MH Risk Assessment and Abatement Tracking data reviewed: • There was no documentation of risk levels and of tracking of actions to closure for five of the nine environmental hazards identified on the locked MH unit.

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.	• Four MSIT members and all five of the occasional MH unit workers had not completed 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.
X	Locked MH units were in compliance with MH EOC Checklist safety requirements or an abatement plan was in place.	• There was no documentation of panic alarm testing for the group room for the past 4 months. • In the recreational room, two sets of audiovisual equipment were unsecured—one on top of a rolling cart and the other on top of a cabinet.
	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.	

Recommendations

5. We recommended that processes be strengthened to ensure that EOC Committee minutes reflect deficiencies identified on the locked MH unit and that MH Risk Assessment and Abatement Tracking data reflect risk levels and tracking of actions to closure for all identified environmental hazards on the locked MH unit.

6. We recommended that processes be strengthened to ensure that access to emergency exits at the Cooper division is unrestricted and that compliance be monitored.

7. We recommended that processes be strengthened to ensure that chemicals stored on the hemodialysis unit are secured at all times and that compliance be monitored.

8. We recommended that processes be strengthened to ensure that all MSIT members and occasional locked MH unit workers 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.

9. 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.

10. We recommended that processes be strengthened to ensure that all audiovisual equipment on the locked MH unit is properly secured.

MM

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 33 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.	

COC

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 32 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.	
	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 three inpatient units (acute medical/surgical, long-term care, and MH).[5]

We reviewed facility and unit-based expert panel documents and 25 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 3 North, CLC unit 27-1, and MH unit 4 South—for 50 randomly selected days between October 1, 2012, and September 30, 2013. The table below shows the areas reviewed for this topic. 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, 30 EHRs of patients with pressure ulcers (10 patients with hospital-acquired pressure ulcers, 10 patients with community-acquired pressure ulcers, and 10 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. 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 had a pressure ulcer prevention policy, and it addressed prevention for all inpatient areas and for outpatient care.	
	The facility had an inter-professional 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.	
	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, inter-professional 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 additional elements required by VHA or local policy.	

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 17 EHRs of residents (10 residents receiving restorative nursing services and 7 residents not receiving restorative nursing services but candidates for services). We also observed two residents during two 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. Any items that did not apply to this facility are marked NA. The facility generally met requirements. We made no recommendations.

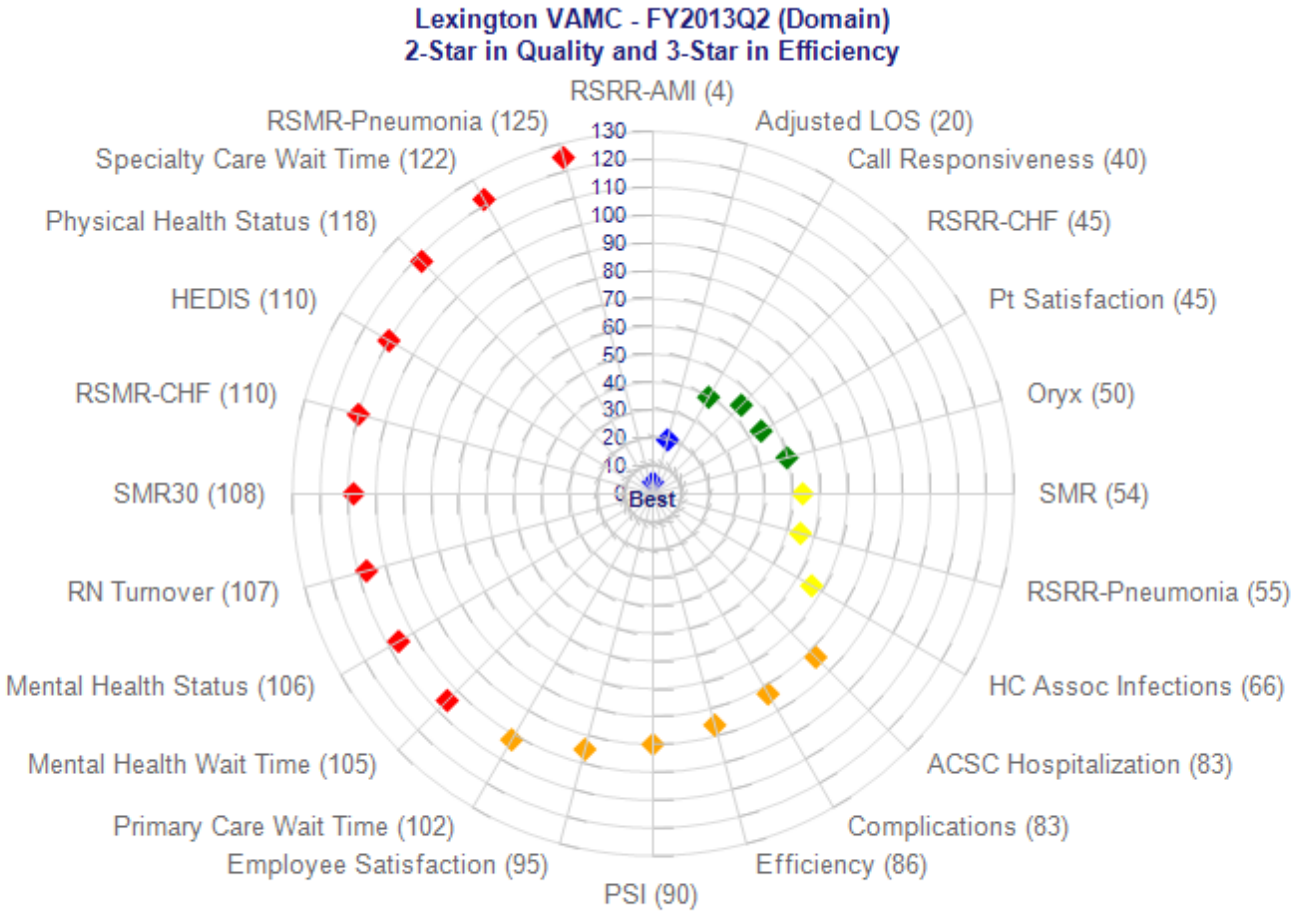
NM	Areas Reviewed	Findings
	The facility offered restorative nursing services.	
	Facility staff completed and documented restorative nursing services, including active and passive range of motion, bed mobility, transfer, and walking activities, according to clinician orders and residents' care plans.	
	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.	
	The facility complied with any additional elements required by VHA or local policy.	
	Areas Reviewed for Assistive Eating Devices and Dining Service	
	Care planned/ordered assistive eating devices were provided to residents at meal times.	
	Required activities were performed during resident meal periods.	

NM	Areas Reviewed for Assistive Eating Devices and Dining Service (continued)	Findings
	The facility complied with any additional elements required by VHA or local policy.	

Facility Profile (Lexington/596) FY 2014 through November 2013[b]	
Type of Organization	Tertiary
Complexity Level	1c-High complexity
Affiliated/Non-Affiliated	Affiliated
Total Medical Care Budget in Millions (September 2013)	$294.3
Number of:	
• **Unique Patients**	23,470
• **Outpatient Visits**	106,083
• **Unique Employees**[c]	1,664
Type and Number of Operating Beds (November 2013):	
• **Hospital**	108
• **CLC**	61
• **MH**	30
Average Daily Census (November 2013):	
• **Hospital**	73
• **CLC**	49
• **MH**	27
Number of Community Based Outpatient Clinics	4
Location(s)/Station Number(s)	Somerset/596GA Morehead/596GB Hazard/596GC Berea/596GD
VISN Number	9

[b] All data is for FY 2014 through November 2013 except where noted.
[c] Unique employees involved in direct medical care (cost center 8200) from most recent pay period.

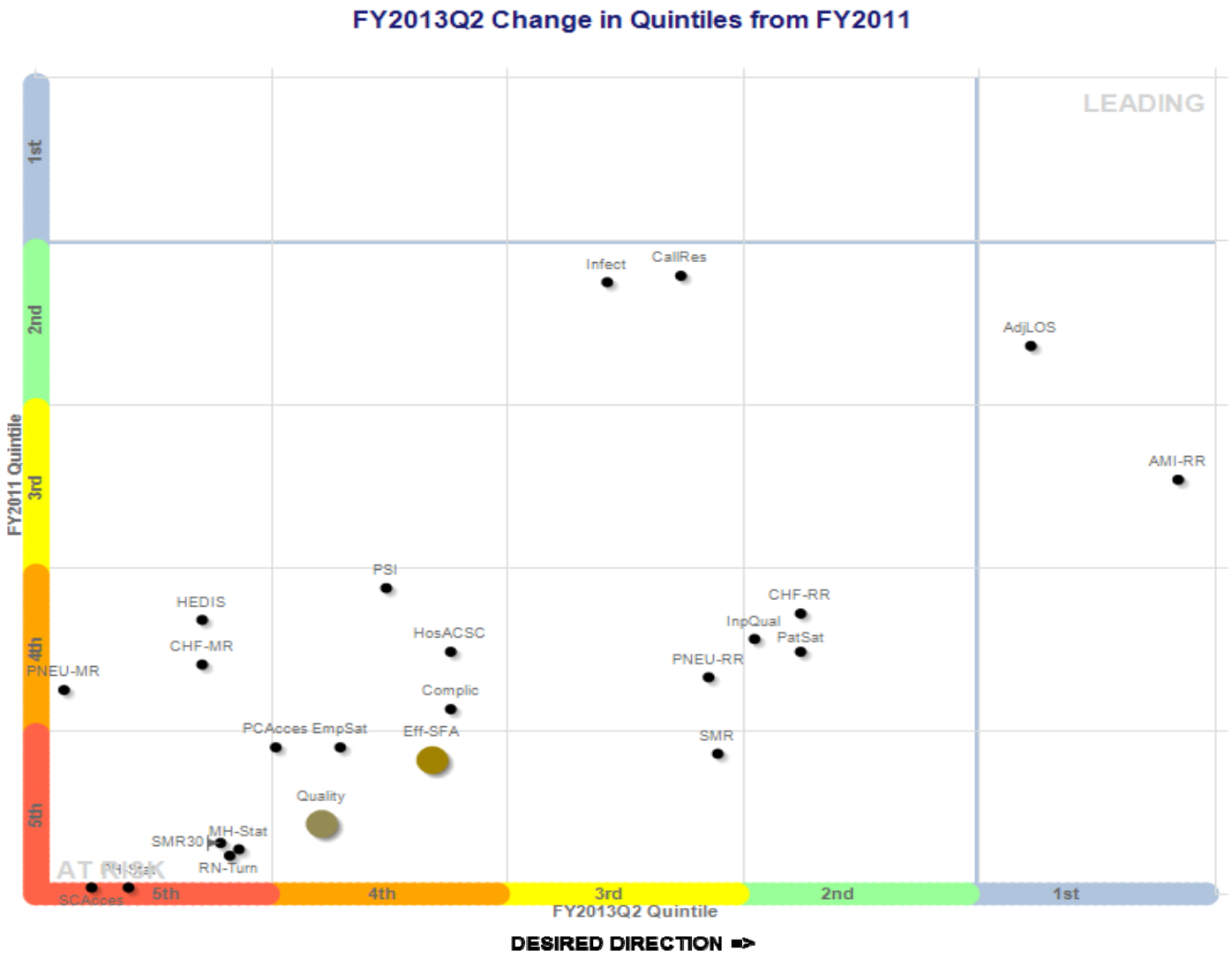
Strategic Analytics for Improvement and Learning (SAIL)[d]



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.

[d] 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 13, 2014

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

Subject: **CAP Review of the Lexington VA Medical Center, Lexington, KY**

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

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

1. Attached please find VAMC Lexington's response to the Office of Inspector General (OIG), Combined Assessment Program (CAP) conducted the week of December 2, 2013.

2. I concur with the Medical Center Director's comments and action plan.

3. If you have any questions or need additional information, please contact Cynthia L. Johnson, VISN 9 Quality Management Officer, or Joseph Schoeck, Staff Assistant to the Network Director at 615-695-2206.

(original signed by:)
John E. Patrick

Facility Director Comments

Department of Veterans Affairs **Memorandum**

Date: January 9, 2014

From: Director, Lexington VA Medical Center (596/00)

Subject: **CAP Review of the Lexington VA Medical Center, Lexington, KY**

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

1. Thank you for the opportunity to review the OIG report. I concur with the findings and recommendations.

2. Our responses to the report recommendations are attached. We have already been actively working on improvements. We appreciate the perspective from the OIG evaluation and will take this opportunity to strengthen and improve our medical center processes.

(original signed by:)
Emma Metcalf, (SES), MSN, RN
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 all that processes be strengthened to ensure that surgical deaths are reviewed by the facility's Surgical Committee.

Concur

Target date for completion: 3/31/2014

Facility response: The Facility Surgical Work Group has oversight for reviewing surgical deaths monthly. Monthly mortalities reviews began in October 2013. Quality Management will perform a monthly audit of the Facility Surgical Work Group minutes until at least 90 percent compliance with surgical mortality review is sustained.

Recommendation 2. We recommended that processes be strengthened to ensure that the critical incident tracking and notification system's recipient list is current.

Concur

Target date for completion: 12/6/2013

Facility response: The Surgical Quality Nurse reviewed the Critical Incident Reporting system recipient list and updated it to include current staff and appropriate back-ups for each position. The Surgical Quality Nurse will validate the list for accuracy on a quarterly basis when she retrieves the VASQIP Facility Report.

Recommendation 3. We recommended that that processes be strengthened to ensure that the Transfusion and Tissue Review Committee member from Anesthesia Service consistently attends meetings.

Concur

Target date for completion: 6/31/2014

Facility response: To ensure attendance of anesthesia service at the Transfusion and Tissue Committee, a designated alternate has been assigned to the committee to cover when the primary anesthesiologist cannot attend. The committee meeting time and place will be placed on the Anesthesia OR Assignment schedule on the day of the meeting so the OR team can plan for the committee member's absence from the OR. The Anesthesiology Service Administrative Officer will alert the committee member the day of the meeting as an additional reminder. Quality Management will perform an

audit of the Transfusion and Tissue Committee minutes attendance record until at least 90 percent compliance with anesthesia service attendance is sustained.

Recommendation 4. We recommended that that processes be strengthened to ensure that the CRC meets monthly and includes physician participation.

Concur

Target date for completion: 3/31/2014

Facility response: A new physician chair and two providers were appointed to the Code Review Committee in July 2013. Quality Management will perform a monthly audit of the Code Review Committee minutes and attendance record until at least 90 percent compliance with meetings and physician attendance is sustained

Recommendation 5. We recommended that processes be strengthened to ensure that EOC Committee minutes reflect deficiencies identified on the locked MH unit and that MH Risk Assessment and Abatement Tracking data reflect risk levels and tracking of actions to closure for all identified environmental hazards on the locked MH unit.

Concur

Target date for completion: 1/9/2014

Facility response: A Mental Health (MH) Representative was added to the Environment of Care (EOC) Committee in January 2014. The Patient Safety Officer will report monthly to EOC on the EOC deficiencies identified on the locked MH unit and on the results of the every 6 month MH Risk Assessment and Abatement Tracking.

Recommendation 6. We recommended that processes be strengthened to ensure that access to emergency exits at the Cooper division is unrestricted and that compliance be monitored.

Concur

Target date for completion: 3/31/2014

Facility response: The equipment was moved immediately from the emergency exits. Acceptable storage area for equipment was designated with caution tape and signage. The staff was educated. The Nurse Manager will monitor and reported monthly to EOC for 6 months.

Recommendation 7. We recommended that processes be strengthened to ensure that chemicals stored on the hemodialysis unit are secured at all times and that compliance be monitored.

Concur

Target date for completion: 3/31/2014

Facility response: The chemicals stored in the hemodialysis unit have been removed and secured. Only chemicals needed for treatment are brought to the treatment area. A New Nurse's station with lockable cabinets has been ordered and will be installed within the next 90 days. The nurse manager will monitor and report monthly to the EOC Committee until compliance is sustained.

Recommendation 8. We recommended that processes be strengthened to ensure that all MSIT members and occasional locked MH unit workers 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: 2/13/2014

Facility response: The Multidisciplinary Safety Inspection Team (MSIT) members and MH unit occasional workers supervisors were notified of MH EOC training requirements on 12/4/13. Staff are to have training completed by 1/30/2013. The MH representative is to report on training compliance to the EOC Committee.

Recommendation 9. 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.

Concur

Target date for completion: 1/9/2014

Facility response: All panic devices have been tested and are operational. Staff have been educated on how to enter work order when a panic alarm is not functioning. Police Service is reporting monthly to EOC on panic alarm testing; dysfunctional devices and that work orders are entered.

Recommendation 10. We recommended that processes be strengthened to ensure that all audiovisual equipment in the locked MH unit is properly secured.

Concur

Target date for completion: 2/13/2014

Facility response: The audiovisual cart was bolted to the floor and the equipment on the cart was secured with metal straps that include tamper resistant screws. This was completed on 12/6/2013. The MH EOC Survey was conducted on 1/8/14. Staff will be educated on the MH EOC to ensure a safe environment.

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