Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 13-03655-84

Combined Assessment Program Review of the VA Salt Lake City Health Care System Salt Lake City, Utah

February 25, 2014

Washington, DC 20420

To Report Suspected Wrongdoing in VA Programs and Operations
Telephone: 1-800-488-8244
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Glossary

CAP	Combined Assessment Program
HER	electronic health record
EOC	environment of care
Facility	VA Salt Lake City Health Care System
FPPE	Focused Professional Practice Evaluation
FY	fiscal year
LGBT	Lesbian, Gay, Bisexual, and Transgender
MEC	Medical Executive Committee
MH	mental health
NA	not applicable
NM	not met
OIG	Office of Inspector General
PRC	Peer Review Committee
PU	pressure ulcer
QM	quality management
RN	registered nurse
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Table of Contents

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 18, 2013.

Review Results: The review covered six activities. The facility's reported accomplishments were transitional housing for homeless veterans, a nurse residency program, and health care equity leader status.

Recommendations: We made recommendations in all six of the following activities:

Quality Management: Consistently initiate and complete Focused Professional Practice Evaluations. Gather data about observation bed use. Consistently perform continuing stay reviews on at least 75 percent of patients in acute beds. Ensure the Blood Transfusion Committee members from Surgery and Anesthesia Services attend meetings.

Environment of Care: Ensure patient care areas are clean, and store clean and dirty items separately. Remove expired medications and supplies from patient care areas.

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

Coordination of Care: Identify aftercare needs, and include them in discharge planning and discharge instructions. Ensure patients receive ordered aftercare services or supplies within the ordered/expected timeframe. Assess patients' and/or caregivers' knowledge and learning abilities during the inpatient stay.

Nurse Staffing: Monitor the recently implemented staffing methodology.

Pressure Ulcer Prevention and Management: Perform and document a patient skin inspection and risk scale upon discharge. Accurately document location, stage, risk scale score, and date pressure ulcer acquired for all patients with pressure ulcers. Provide and document pressure ulcer education for patients at risk for and with pressure ulcers and/or their caregivers. Consistently notify the wound care team when an admitted patient has a skin risk of 14 or below.

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 19–29, 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 six activities:

- QM
- EOC
- Medication Management
- Coordination of Care
- Nurse Staffing
- PU Prevention and Management

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 November 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 VA Salt Lake City Health Care System, Salt Lake City, Utah, Report No. 10-03093-82, February 7, 2011).

During this review, we presented crime awareness briefings for 543 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 we received 323 responses. We shared summarized results with facility managers.

In this report, we make recommendations for improvement. Recommendations pertain to issues that are significant enough to be monitored by the OIG until corrective actions are implemented.

Reported Accomplishments

Transitional Housing for Homeless Veterans – Valor House

The facility, in partnership with the Housing Authority of Salt Lake City, dedicated the new 72-bed Valor House to better serve veterans who are eligible for VA services and are homeless or in imminent danger of becoming homeless. This transitional housing can accommodate veterans for up to 24 months, with the goal of helping them achieve independence. Facility staff provide ongoing support and case management. In addition to the 72 beds (each in a private room with a bath), the Valor House includes a front desk, an interior recreation area, a library, and 12 community kitchens. It also has an outdoor patio with a basketball court.

Nurse Residency Program

The facility served as a pilot site for the VA post-baccalaureate nurse residency program. This program allows for six new graduates to be selected as RN residents and provides opportunities in supervised clinical experience and didactic learning that focus on the development of organizational and leadership skills, a better understanding of the nursing process and their role within, and a more in-depth review of specialized clinical procedures. In addition, each cohort of residents must complete team evidence-based projects. Five RN residents gained employment at the facility in September 2013.

Health Care Equity Leader

In 2013, the facility was recognized as a leader in promoting equitable and inclusive care for LGBT patients and their families. To achieve health care equity leader status, the facility publicized to its patients and visitors through the patient handbook and visitation signage VHA's system-wide policies granting equal visitation to LGBT individuals and prohibiting LGBT patient and employment discrimination.

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.	
X	FPPEs for newly hired licensed independent practitioners were initiated, completed, and reported to the MEC.	Twenty-eight profiles reviewed: • Three FPPEs were not initiated. • Of the 25 FPPEs initiated, 17 were not completed.
	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
X	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 re-assessed timely.	• The facility did not gather observation bed use data.
X	Staff performed continuing stay reviews on at least 75 percent of patients in acute beds.	• For the 1 month of continuing stay data available, less than 75 percent of acute inpatients were reviewed. The facility did not have continuing stay data for the remaining 11 months.
	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.	
	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.	
	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.	Four quarters of the Blood Transfusion Committee meeting minutes reviewed: • Clinical representatives from Surgery and Anesthesia Services did not attend any of the 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 processes be strengthened to ensure that FPPEs for newly hired licensed independent practitioners are consistently initiated and completed.

2. We recommended that processes be strengthened to ensure that data about observation bed use is gathered.

3. We recommended that processes be strengthened to ensure that continuing stay reviews are consistently performed on patients in acute beds and that they are completed on at least 75 percent of acute care patients.

4. We recommended that processes be strengthened to ensure that members from Surgery and Anesthesia Services attend Blood Transfusion Committee meetings.

EOC

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

We inspected the medical and surgical intensive care, the two medical/surgical, and the acute MH inpatient units. We also inspected the emergency department, the gastrointestinal laboratory, a primary care clinic, and the radiology department. Additionally, we reviewed relevant documents, conversed with key employees and managers, and reviewed 29 employee training records (10 radiology employees, 10 acute MH unit employees, 5 Multidisciplinary Safety Inspection Team members, and 4 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.	• Five of eight patient care areas were not clean. • Two walls in MH had large stained areas.
X	Infection prevention requirements were met.	• In three of eight patient care areas, clean and dirty items were not stored separately. • In two of eight patient care areas, we found expired supplies.
X	Medication safety and security requirements were met.	• We found expired medications in five of eight patient care areas and in the radiology medication room.
	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
	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.	
	The locked MH unit(s) was/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

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

6. We recommended that processes be strengthened to ensure that clean and dirty items are stored separately and that compliance be monitored.

7. We recommended that processes be strengthened to ensure that expired medications and supplies are removed from patient care areas 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 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
X	Clinicians conducted inpatient learning assessments within 24 hours of admission or earlier if required by local policy.	• Eleven patients (31 percent) did not have documented learning assessments.
X	If learning barriers were identified as part of the learning assessment, medication counseling was adjusted to accommodate the barrier(s).	• Of the 13 patients with identified learning barriers, EHR documentation did not reflect medication counseling accommodation to address the barriers for 12 patients.
	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.	

Recommendations

8. We recommended that processes be strengthened to ensure that patient learning assessments are conducted and documented and that compliance be monitored.

9. 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 35 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. 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
X	Patients' post-discharge needs were identified, and discharge planning addressed the identified needs.	Patients' post-discharge needs were not addressed during discharge planning for: • Restricted/special diets—4 of 33 patients (12 percent) • Wound care/dressing changes—12 of 15 patients • Prosthetics—four of six patients
X	Clinicians provided discharge instructions to patients and/or caregivers and validated their understanding.	Clinicians did not provide discharge instructions to patients and/or caregivers for: • Restricted/special diets—5 of 33 patients (15 percent) • Wound care/dressing changes—9 of 11 patients • Prosthetics—four of six patients
X	Patients received the ordered aftercare services and/or items within the ordered/expected timeframe.	• Eleven of the 21 patients who had services or supplies ordered did not receive them within the ordered/expected timeframe.
X	Patients' and/or caregivers' knowledge and learning abilities were assessed during the inpatient stay.	• Thirteen of the 35 EHRs (37 percent) did not contain documentation that the patients' and/or caregivers' knowledge and learning abilities were assessed during the admission. • Twenty of the 22 applicable EHRs did not contain documentation that patients' and/or caregivers' knowledge and learning abilities were assessed at the time that discharge instructions were provided.
	The facility complied with any additional elements required by VHA or local policy.	

Recommendations

10. We recommended that processes be strengthened to ensure that aftercare needs are identified and included in discharge planning and discharge instructions.

11. We recommended that processes be strengthened to ensure that patients receive ordered aftercare services or supplies within the ordered/expected timeframe.

12. We recommended that processes be strengthened to ensure that patients' and/or caregivers' knowledge and learning abilities are assessed during the inpatient stay.

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 relevant documents, and we conversed with key employees. 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
X	The facility either implemented or reassessed a nurse staffing methodology within the expected timeframes.	• The facility did not fully implement VHA's staffing methodology until September 2013 when unit-based expert panels were formed.
	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.	

Recommendation

13. We recommended that nursing managers monitor the recently implemented staffing methodology.

PU Prevention and Management

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

We reviewed relevant documents, 21 EHRs of patients with PUs (10 patients with hospital-acquired PUs, 10 patients with community-acquired PUs, and 1 patient with PUs at the time of our onsite visit), and 10 employee training records. Additionally, we inspected one patient room. 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 PU prevention policy, and it addressed prevention for all inpatient areas and for outpatient care.	
	The facility had an interprofessional PU committee, and the membership included a certified wound care specialist.	
	PU data was analyzed and reported to facility executive leadership.	
	Complete skin assessments were performed within 24 hours of acute care admissions.	
X	Skin inspections and risk scales were performed upon transfer, change in condition, and discharge.	• Ten of the 20 applicable EHRs did not contain documentation that a skin inspection and risk scale were performed upon discharge.
X	Staff were generally consistent in documenting location, stage, risk scale score, and date acquired.	• In 13 of the 21 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 PUs and for patients with PUs.	
	Required activities were performed for patients determined to not be at risk for PUs.	
	For patients at risk for and with PUs, interprofessional treatment plans were developed, interventions were recommended, and EHR documentation reflected that interventions were provided.	
	If the patient's PU was not healed at discharge, a wound care follow-up plan was documented, and the patient was provided appropriate dressing supplies.	
X	The facility defined requirements for patient and caregiver PU education, and education on PU prevention and development was provided to those at risk for and with PUs and/or their caregivers.	Facility PU patient and caregiver education requirements reviewed: • For 10 of the 17 applicable patients at risk for/with a PU, EHRs did not contain evidence that education was provided.

NM	Areas Reviewed (continued)	Findings
	The facility defined requirements for staff PU education, and acute care staff received training on how to administer the PU risk scale, conduct the complete skin assessment, and accurately document findings.	
	The facility complied with selected fire and environmental safety, infection prevention, and medication safety and security requirements in PU patient rooms.	
X	The facility complied with any additional elements required by VHA or local policy.	Local Nursing Service policy on PU risk management reviewed: • For 10 of the 15 applicable EHRs, staff did not consistently notify the wound care team when patients were at moderate risk to develop PUs.

Recommendations

14. We recommended that processes be strengthened to ensure that acute care staff perform and document a patient skin inspection and risk scale upon discharge and that compliance be monitored.

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

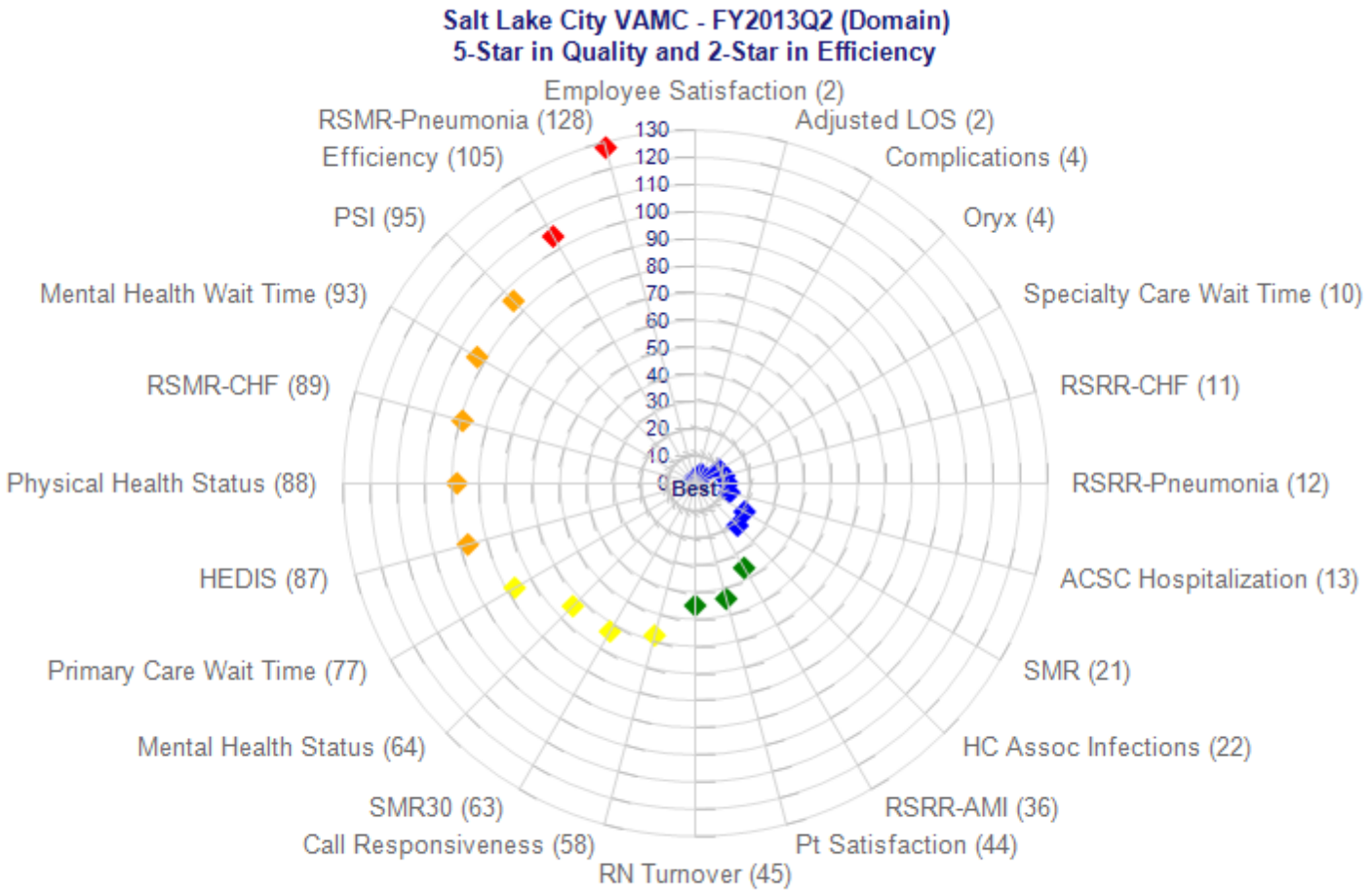
16. We recommended that processes be strengthened to ensure that acute care staff provide and document PU education for patients at risk for and with PUs and/or their caregivers and that compliance be monitored.

17. We recommended that processes be strengthened to ensure that staff consistently notify the wound care team when an admitted patient has a skin risk of 14 or below.

Facility Profile (Salt Lake City/660) FY 2014 through November 2013[a]	
Type of Organization	Tertiary
Complexity Level	1b-High complexity
Affiliated/Non-Affiliated	Affiliated
Total Medical Care Budget in Millions (September 2013)	$403.7
Number of:	
• **Unique Patients**	31,078
• **Outpatient Visits**	141,926
• **Unique Employees**[b]	1,788
Type and Number of Operating Beds:	
• **Hospital**	106
• **Community Living Center**	N/A
• **MH**	15
Average Daily Census:	
• **Hospital**	79
• **Community Living Center**	N/A
• **MH**	13
Number of Community Based Outpatient Clinics	9
Location(s)/Station Number(s)	Pocatello/660GA Ogden/660GB Ely/660GC Roosevelt/660GD Orem/660GE St. George/660GG Nephi/660GI West Valley City/660GJ Elko, NV/660GK
VISN Number	19

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

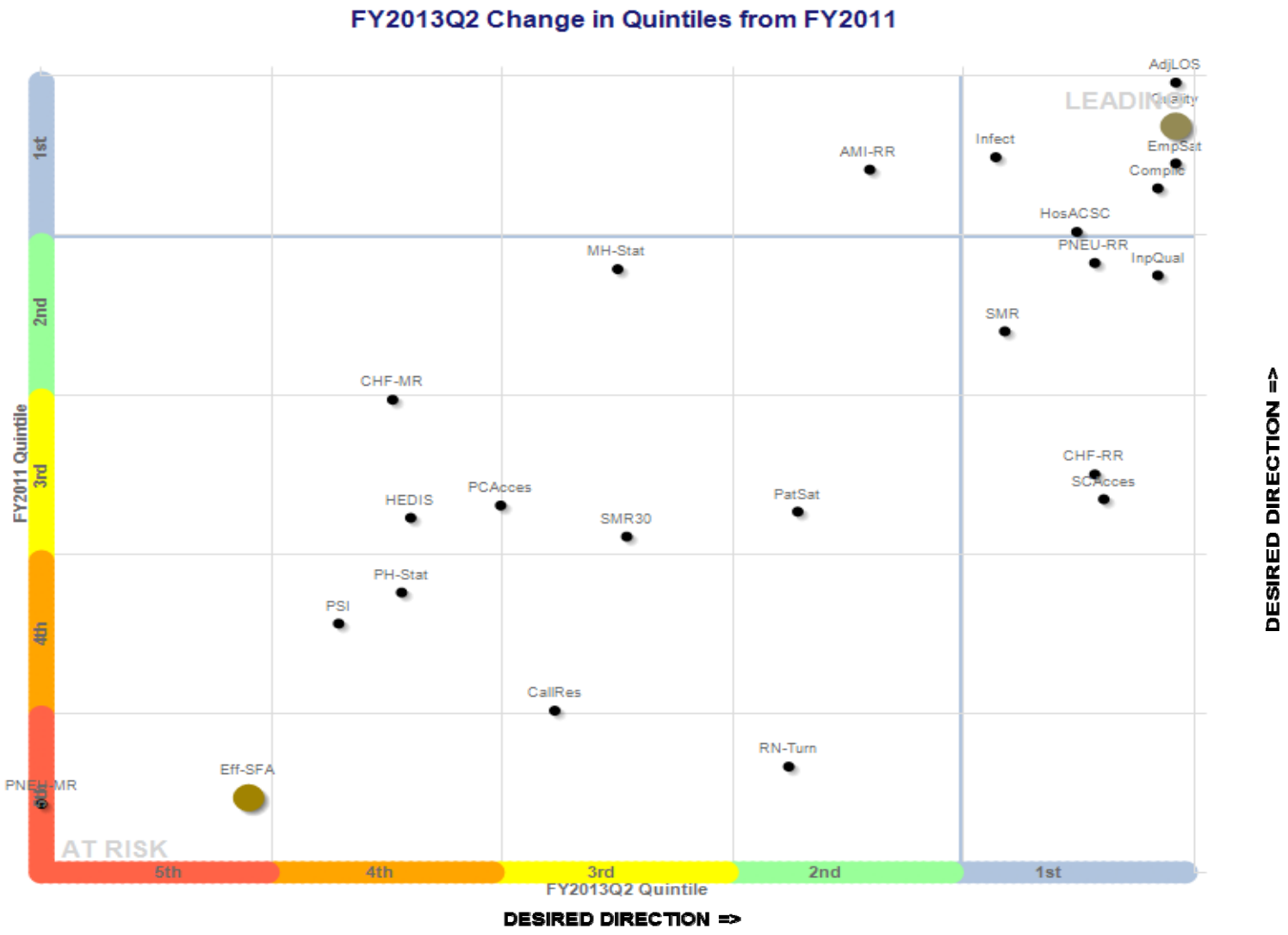
Strategic Analytics for Improvement and Learning (SAIL)[c]



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	RN 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 24, 2014

From: Director, Rocky Mountain Network (10N19)

Subject: **CAP Review of the VA Salt Lake City Health Care System, Salt Lake City, UT**

To: Director, Los Angeles Office of Healthcare Inspections (54LA)

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

1. Thank you for the opportunity to respond to the proposed recommendations for the VA Salt Lake City Health Care System, Salt Lake City, Utah.
2. Attached please find the facility concurrences and responses to each of the findings from the review.
3. If you have additional questions or need further information, please contact Aggie Worth, VISN 19 QMO at (303) 639-6984.

RALPH T. GIGLIOTTI, FACHE
Director, VA Rocky Mountain Network 19

Facility Director Comments

Department of Veterans Affairs **Memorandum**

Date: January 23, 2014

From: Director, VA Salt Lake City Health Care System (660/00)

Subject: **CAP Review of the VA Salt Lake City Health Care System, Salt Lake City, UT**

To: Director, Rocky Mountain Network (10N19)

1. Thank you for the opportunity to submit responses to the proposed recommendations for the VA Salt Lake City Health Care System, Salt Lake City, Utah.

2. I have reviewed and concur with the findings and recommendations in the draft report of the Office of the Inspector General Combined Assessment Program Review conducted the week of November 18, 2013.

3. Corrective action plans have been established, with some being already implemented, and target completion dates have been set for the remaining items as detailed in the attached report.

4. Should you have any questions, please contact Nena Saunders, Associate Director, Quality and Safety, 801-582-1565, extension 4608.

Steve Young

STEVEN W. YOUNG, FACHE
Director

Comments to OIG's Report

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

OIG Recommendations

Recommendation 1. We recommended that processes be strengthened to ensure that FPPEs for newly hired licensed independent practitioners are consistently initiated and completed.

Concur

Target date for completion: Actions have been in place since March 2013.

Facility response: For the past 10 months, since March 2013, the facility has had a process in place which ensures FPPEs for newly hired independent practitioners are consistently initiated and completed. Once a provider is credentialed and privileges are approved, the Credentialing staff sends a letter to each new provider outlining the individualized criteria which will be used to evaluate their performance at 90-days or earlier in the cases determined to have close oversight. (New providers typically). The Professional Standard Boards (PSB) minutes are structured to remind Service Chiefs of pending FPPEs. Each meeting the Chairman of the PSB will call for the review of those FPPEs which are due. The Service Chief has completed the evaluation of these individualized data and present findings with a recommendation to the Professional Standards Board. The Chief of Staff and the Director review each provider folder and approve or disapprove the board's recommendations. The Chairman of the Professional Standards Board draws each committee members' attention to reviews due at the next meeting.

The Credentialing and Privileging staff also have developed a tracking system which include the name of the provider, service, date boarded through PSB/CEB, date of first patient encounter & FPPE initiated, FPPE due date, FPPE completed and date it was closed in committee.

Recommendation 2. We recommended that processes be strengthened to ensure that data about observation bed use is gathered.

Concur

Target date for completion: Completed

Facility response: Observation bed data has consistently been gathered since October 1, 2013 and will continue to be gathered and reported to Clinical Executive Board.

Recommendation 3. We recommended that processes be strengthened to ensure that continuing stay reviews are consistently performed on patients in acute beds and that they are completed on at least 75 percent of acute care patients.

Concur

Target date for completion: April 1, 2014

Facility response: Another UM nurse was hired and began working December 16, 2013. This additional FTE will increase the continuing stay reviews. One additional FTE will be added to insure the facility can accomplish 75 percent of continuing stay reviews on acute care patients.

Recommendation 4. We recommended that processes be strengthened to ensure that members from Surgery and Anesthesia Services attend Blood Transfusion Committee meetings.

Concur

Target date for completion: Completed December 16, 2013

Facility response: The Chief of Staff made new committee assignments from the Surgery and Anesthesia department to serve on the Blood Transfusion Committee. The Chief of Staff stressed the criticality of their consistent attendance. The Committee policy has been modified to allow for virtual attendance via telephone or v-tel if needed. The Blood Transfusion Committee meets quarterly and reports to the Clinical Executive Board quarterly. Attendance of these 2 services will be monitored by the Chief of Quality Management for the next year.

Recommendation 5. We recommended that processes be strengthened to ensure that patient care areas are clean and that compliance be monitored.

Concur

Target date for completion: April 1, 2014

Facility response: Using ISSA housekeeping staffing standards (adopted by VACO) the facility will recruit and hire 10 additional staff. Supervisor staff will insure compliance and cleanliness are monitored at least twice per week. Nursing staff will be responsible to maintain equipment cleanliness and a campaign to bring awareness to these responsibilities has begun. The campaign, taken from the comments of one of our surveyors is titled “Don’t Stop at the Top” urging bases of equipment, stretchers; scales have a routine cleaning schedule. Nurse Managers will be responsible to monitor cleanliness of equipment and report monthly to Quality Management. Weekly environment of care rounds are conducted throughout the facility and the CBOCs insuring a comprehensive inspection at least every six months is conducted at each facility department and CBOC location.

Recommendation 6. We recommended that processes be strengthened to ensure that clean and dirty items are stored separately and that compliance be monitored.

Concur

Target date for completion: June 1, 2014

Facility response: A multidisciplinary team has been convened to conduct a full inventory of clean/dirty spaces in the facility. Original facility design delineated full separate spaces for strict clean and dirty rooms. Over time and without authority rooms were designated for other use. The multi-disciplinary team will conduct an inspection of each clinical area, consulting original design drawings and designated clean and dirty rooms will be re-claimed for the original planned use. The full inspection will be conducted by March 15, 2014 and reclamation of the space that has been assigned to another function will occur by June 1, 2014.

Recommendation 7. We recommended that processes be strengthened to ensure that expired medications and supplies are removed from patient care areas and that compliance be monitored.

Concur

Target date for completion: March 1, 2014

Facility response: Clinical managers have developed systems within their departments to insure no expired medications and supplies are in the inventory. Managers will be assigning particular areas within the department to individual staff members for insuring medications and supplies are inventoried monthly and expiring products are removed from inventory. Monthly reports will be provided to the Quality Manager for compliance monitoring. Participants on Environment of Care rounds will inspect weekly for outdated supplies and medications. Noncompliance will be reflected in employee evaluations.

Recommendation 8. We recommended that processes be strengthened to ensure that patient learning assessments are conducted and documented and that compliance be monitored.

Concur

Target date for completion: April 1, 2014

Facility response: Staff have been re-educated on this requirement. Compliance reports will be collected by the Quality Manager through an electronic report. Once these reports are made available we will be able to target particular providers who are not completing learning assessments and work individually with them.

Recommendation 9. 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: April 1, 2014

Facility response: Staff have been re-educated on this requirement and the documentation requirements. Thirty records per month will be reviewed for compliance within the quality department and reported to the Clinical Executive Board.

Recommendation 10. We recommended that processes be strengthened to ensure that aftercare needs are identified and included in discharge planning and discharge instructions.

Concur

Target date for completion: March 1, 2014

Facility response: The Discharge Brochure will be updated by March 1, 2014 and provided to all patients upon admission to an acute care unit. This brochure includes information regarding the discharge process and the importance of communication among patients, family and staff to ensure patient needs are met. It also includes hospital address and phone number and a discharge checklist for the patients. Nursing, social work, pharmacy and dietary are involved in this revision.

Improved Discharge Instructions – Both medicine and surgery are updating their discharge instructions. Nurse Physician Liaisons and Pharmacy are involved in reformatting instructions for better readability. In the past, the medication section was confusing for patients. Improvements will include a user friendly medication list (displayed after med reconciliation). Process will allow last minute medication changes to be incorporated. There will also be a box at the bottom of the instructions that providers can click stating that "Patient has medications in the pharmacy."

Interdisciplinary Discharge Meeting – In addition to daily patient rounds, the surgery interdisciplinary team meets every Wednesday to review status/needs of all patients on the Acute Surgery Unit and those discharging directly from SICU. The medicine interdisciplinary team meets every Monday and Thursday to review status/needs of all patients discharging from Acute Medicine, Telemetry, and MICU.

Post Discharge Telephone Contact – Staff continue to improve the utilization of information provided by post discharge calls. Questions asked during these calls, which are made within 48 hours of discharge, cover many topics including whether or not patient received discharge instructions, medications, and equipment. If patient has any concerns, they are answered at the time of the call or forwarded to the appropriate

person for follow-up. In addition, individuals making post discharge calls are encouraged to contact the unit manager if any concerning trends are noted.

Recommendation 11. We recommended that processes be strengthened to ensure that patients receive ordered aftercare services or supplies within the ordered/expected timeframe.

Concur

Target date for completion: April 1, 2014

Facility response:

Prosthetics and Sensory Aid Service (PSAS) – PSAS developed an SOP for the receipt of consults and durable medical equipment (DME) and supplies used in the home. All staff has been educated on the SOP.

Infusion Service – Infusion nurses meet weekly with our two contract home pharmacies and review every patient. This provides them updates on patient progress and gives us the opportunity to review patients to ensure that they are receiving the care that is needed and was ordered. Additionally, our process involves the contract home pharmacies contacting us when they receive each new referral. Prior to them contacting us they coordinate with the assigned home health agency.

This process gives us multiple opportunities to validate that the patient is receiving the ordered care while also providing us with feedback about potential additional needs. Revisions are made to Home IV Therapy referrals based on changes in patient condition, changes in ordered therapy, and evaluation of our partner home health nursing agencies and contract home pharmacies.

Home Health agency – We have developed and are piloting a new process for using electronic communication to improve the timeliness and accuracy of information exchange with home health agencies that are contracted to care for Veterans. This process removes the need for any paper, mail, or faxed based communication by using a direct secure email system that incorporates care plans directly into the electronic medical record. We are also developing requirements and working with a Federally Funded Research Development Center to pilot a more advanced system of communication that would use a secure internet based communication system to certify and update home health care plans.

Post Discharge Telephone Contact – Staff continue to improve the utilization of information provided by post discharge calls. Questions asked during these calls, which are made within 48 hours of discharge, cover many topics including whether or not patient received discharge instructions, medications, and equipment. If patient has any concerns, they are answered at the time of the call or forwarded to the appropriate person for follow-up. In addition, individuals making post discharge calls are encouraged to contact the unit manager if any concerning trends are noted.

All processes will be monitored and reported to the Quality Manager. The Quality Manager will provide a quarterly report of OIG findings and progress to the Executive Board. The initial report (Quarter 3: April–May–June) will be due to Quality Management by July 15, 2014 and reported to the next regularly scheduled Executive Board within one month.

Recommendation 12. We recommended that processes be strengthened to ensure that patients' and/or caregivers' knowledge and learning abilities are assessed during the inpatient stay.

Concur

Target date for completion: March 1, 2014

Facility response:

Standardizing assessment tool used by providers – Medical Staff leadership are evaluating tools/methods of assessing inpatients for decision making capacity. A standardized approach will be implemented by March 1, 2014 and monthly monitoring for compliance will be conducted and reported to the Executive Board.

Nursing Admission Assessment – The admission assessment used by all inpatient nurses will be improved to include additional mandatory fields that will specifically address patient's knowledge and learning abilities. Automatic consult options (low vision, audiology, etc) will be added to assessment template to maximize expertise/resources available for patient learning. Specialty services will provide education to nurses to ensure that the consults are appropriate.

Recommendation 13. We recommended that nursing managers monitor the recently implemented staffing methodology.

Concur

Target date for completion: July 31, 2014

Facility response: Since Sept 2013, we've had the Unit Based panels in place, all panel members have completed TMS (Talent Management System) training, and the members have been meeting monthly with the FEP (Facility Expert Panel) to learn the process and discuss staffing issues. We will begin the 2014 6-month data collection phase in February 2014–July 2014.

Recommendation 14. We recommended that processes be strengthened to ensure that acute care staff perform and document a patient skin inspection and risk scale upon discharge and that compliance be monitored.

Concur

Target date for completion: March 1, 2014

Facility response: The facility is taking a 4-prong approach including Documentation structure, staff education, monitoring and support of performance.

Documentation – To ensure that nurses assess patient and document Braden Skin Assessment at least every 24 hours, the Braden Scale will be made a mandatory field in all inpatient nursing shift assessments.

Shift assessment on day of discharge templates will include complete skin assessment, risk scale and, if pressure ulcer is present, documentation of PU stage, measurement, and wound bed description. This template will be embedded into the nursing assessment.

Education – Enterostomal Therapy (ET) Nurses will provide education to staff on Braden scale and how to assess patient risk. This education will be available during nursing orientation period and at unit staff meetings.

By February 15, 2014, laminated posters with best practices for preventing pressure ulcers will be distributed to inpatient nursing break rooms.

Enterostomal Therapy Nurses will provide Skin Champions with a checklist to be used to detail the type of wound assessment and documentation needed upon admission and discharge, and also when staging and measuring a pressure ulcer. Nurses will document that the pressure ulcer prevention handout was given and reviewed with the patient at the time of discharge.

Reporting/Monitoring – Monday–Friday, data warehouse will provide a daily report to Nurse Managers listing patients who have not had a Braden Scale completed in past 24 hours. Nurse Managers will follow up with nurse who should have completed Braden Skin and Risk assessment and nurse caring for the patient that day. They will ensure that the Braden scale is completed promptly. Nurse Managers or designee will perform spot audits on patients discharged to assess for compliance with Braden skin and risk assessments. For all patients with documented pressure ulcers, an Enterostomal Therapy consult for outpatient follow-up will be generated by discharging nurse.

Recommendation 15. We recommended that processes be strengthened to ensure that acute care staff accurately document location, stage, risk scale score, and date PU acquired for all patients with PUs and that compliance be monitored.

Concur

Target date for completion: March 1, 2014

Facility response: A 4-prong approach is being taken to strengthen staff documentation, compliance monitoring and support.

Education/Documentation – All pressure ulcers will need a 2 person confirmation to ensure accuracy. Each unit will have at least 2 Skin Team Champions (STC) to assist

with education dissemination. The STC will be part of the hospital Skin Team and will attend monthly team meetings. When the nurse identifies a wound as a pressure ulcer, the STC will confirm the pressure ulcer, staging, measurement, wound description, risk assessment, prevention interventions, treatment, and note date PU acquired (i.e. either community or hospital acquired). The STC will co-sign the note to confirm the diagnosis of a pressure ulcer.

If the STC is not available then the discovering nurse will contact Enterostomal Service for confirmation. On off tours, nursing will document as "wound" until confirmation can be done at earliest opportunity by STC or Enterostomal Therapy Nurse. On the designated day (per week) the STC will, with the bedside nurse, review the pressure ulcer including measurements, wound description, risk assessment interventions planned and completed, and treatment. Additionally, patient or caregiver education will be documented.

Monitoring – Enterostomal Service will monitor daily VANOD (VA Nursing Outcomes Database) skin reports for all patients identified with a pressure ulcer. Enterostomal Service will review weekly documentation for all patients with pressure ulcers for completeness. If documentation is incomplete, the Enteorstomal Service will contact STC to rectify. If the documentation is in error (i.e. pressure ulcer identified one day but is misdiagnosed the next day), the Enterostomal Service will notify the Nurse Manager to take corrective action by having an addendum skin assessment added to incorrect note correcting documentation. Enteorstomal Service will work with VANOD nurse and CACs (Clinical Application Coordinators) to correct Health Factors.

Reporting – Enterostomal Service will provide a monthly report to Associate Director Patient Care Services and each Nurse Manager with the number of pressure ulcers on each unit, documentation accuracy and completeness. This unit information will also be posted for the nursing staff to facilitate benchmarking and improvement efforts. Enterostomal Service will review compliance with PU identification, documentation and tracking in the monthly Skin Team meeting.

Support – Enteorstomal Service will provide STC education and certification.Enterstomal Service to provide documentation template for STC use.

Recommendation 16. We recommended that processes be strengthened to ensure that acute care staff provide and document PU education for patients at risk for and with PUs and/or their caregivers and that compliance be monitored.

Concur

Target date for completion: March 1, 2014

Facility response:

Education/Documentation – During hospitalization, daily interventions will be identified and documented as completed by the nursing staff. There will be documentation

evidence in the medical record that preventive interventions were reviewed with the patient.

Compliance will be documented. Weekly documentation of interventions and patient education is also found with the STC (Skin Team Champion) assessment.

Monitoring Plan – STC will review active inpatient education for those patients with known Pressure Ulcers. Review will include current interventions, completion of interventions and education of the patient and or caregiver as to the need and continuance of those interventions.

Recommendation 17. We recommended that processes be strengthened to ensure that staff consistently notify the wound care team when an admitted patient has a skin risk of 14 or below.

Concur

Target date for completion: March 1, 2014

Facility response:

Consultation/Education – Nursing will initiate an Enterostomal consult for all patients with a Braden risk score of 14 and below. Enterostomal Service will respond to consult with a bedside patient review with the bedside nurse. Together a care plan will be made and documented by the bedside nurse in the VANOD (VA Nursing Outcomes Database) skin assessment. Enterostomal Service will also document encounter with a Point of Care note to be co-signed by the bedside nurse, the Nurse Manager, and the Skin Champion.

Monitoring – Enterostomal Service will monitor daily skin reports for patients with a Braden risk score 14 or lower. If there is a patient with a risk score 14 or lower and Enterostomal Service has not been notified, Enteorstomal Service will alert Nurse Manager of discrepancy. Enteorstomal Service will then review patient at bedside with bedside nurse to formulate care plan. The bedside nurse at that time will place the Enterostomal consult. Nurse Manager will provide 1:1 education/counseling for staff non-compliant with ET consultation.

Reporting – Enterostomal Service will provide a monthly report on compliance of consults for patients with Braden risk scores of 14 or lower. Intervention and education will be reported as noted above in recommendation 14, 15 and 16.

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Endnotes

[1] References used for this topic included:
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[3] References used for this topic included:
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- VHA Handbook 1108.05, *Outpatient Pharmacy Services*, May 30, 2006.
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- Various requirements of The Joint Commission.

[4] References used for this topic included:
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[5] The references used for this topic were:
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- Various requirements of The Joint Commission.
- Agency for Healthcare Research and Quality Guidelines.
- National PU Advisory Panel Guidelines.
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