Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 13-04241-78

Combined Assessment Program Review of the Boise VA Medical Center Boise, Idaho

February 25, 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

ATV	all-terrain vehicle
CAP	Combined Assessment Program
CLC	community living center
COS	Chief of Staff
EHR	electronic health record
EOC	environment of care
facility	Boise VA Medical Center
FY	fiscal year
MEC	Medical Executive Committee
MH	mental health
NA	not applicable
NM	not met
OIG	Office of Inspector General
PRC	Peer Review Committee
QM	quality management
SCC	Skin Care Council
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 December 2, 2013.

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

- Environment of Care

The facility's reported accomplishment was an all-terrain vehicle experience for veterans with disabilities.

Recommendations: We made recommendations in the following six activities:

Quality Management: Ensure that code reviews include screening for clinical issues prior to the code that may have contributed to the occurrence of the code. Require that the Surgical Invasive Procedure Committee includes the Chief of Staff as a member, monitors surgery performance improvement activities, and documents its review of surgical deaths. Include most services in the review of electronic health record quality.

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

Coordination of Care: Require that discharge instructions are consistent with patients' identified post-discharge needs and that they include all required elements. Ensure the facility has a Veterans Health Education Coordinator and an active Veterans Health Education Committee.

Nurse Staffing: Ensure that the facility expert panel includes all required members and that those members receive the required training prior to the next annual staffing plan reassessment.

Pressure Ulcer Prevention and Management: Ensure that Skin Care Council minutes include analysis of pressure ulcer data and that the council routinely reports program data to facility executive leadership. Accurately document pressure ulcer location and stage for all patients with pressure ulcers. Provide and document pressure ulcer education for patients with pressure ulcers and/or their caregivers. Establish ongoing staff pressure ulcer education requirements.

Community Living Center Resident Independence and Dignity: Complete and document restorative nursing services, or document reasons for discontinuing or not providing those services.

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 19–25, for the full text of the Directors' comments.) We consider recommendations 7 and 8 closed. We will follow up on the planned actions for the open recommendations until they are completed.

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

Objectives and Scope

Objectives

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

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

Scope

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

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

- QM
- EOC
- Medication Management
- Coordination of Care
- Nurse Staffing
- Pressure Ulcer Prevention and Management
- CLC Resident Independence and Dignity

We have listed the general information reviewed for each of these activities. Some of the items listed may not have been applicable to this facility because of a difference in size, function, or frequency of occurrence.

The review covered facility operations for FY 2012, 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 Boise VA Medical Center, Boise, Idaho,* Report No. 10-02984-54, January 10, 2011).

During this review, we presented crime awareness briefings for 142 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 198 responded. We shared summarized results with the facility Director.

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

Reported Accomplishment

Veterans with Disabilities ATV Experience

The facility partnered with the Idaho Recreation Council, ATV clubs, and recreational equipment dealers to provide an ATV experience for veterans with disabilities. Fifteen veterans with disabilities were paired with riding coaches and were able to spend the day enjoying the outdoors.

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 COS and included membership by applicable service chiefs. • Actions from individual peer reviews were completed and reported to the PRC. • The PRC submitted quarterly summary reports to the MEC. • Unusual findings or patterns were discussed at the MEC.	
	Focused Professional Practice Evaluations for newly hired licensed independent practitioners were initiated, completed, and reported to the MEC.	
	Specific telemedicine services met selected requirements: • Services were properly approved. • Services were provided and/or received by appropriately privileged staff. • Professional practice evaluation information was available for review.	

NM	Areas Reviewed (continued)	Findings
	Observation bed use met selected requirements: • Local policy included necessary elements. • Data regarding appropriateness of observation bed usage was gathered. • If conversions to acute admissions were consistently 30 percent or more, observation criteria and utilization were reassessed timely.	
	Staff performed continuing stay reviews on at least 75 percent of patients in acute beds.	
X	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.	Twelve months of Critical Care and Cardiopulmonary Resuscitation Committee (formerly the Critical Care Committee and the Code Blue Review Committee) meeting minutes reviewed: • There was no evidence that code reviews included screening for clinical issues prior to the code that may have contributed to the occurrence of the code.
X	The surgical review process met selected requirements: • An interdisciplinary committee with appropriate leadership and clinical membership met monthly to review surgical processes and outcomes. • All surgical deaths were reviewed. • Additional data elements were routinely reviewed.	Twelve months of Surgical Invasive Procedure Committee meeting minutes reviewed: • The COS was not a member. • There was no evidence that surgery performance improvement activities were monitored or that surgical deaths were reviewed by the committee.
	Critical incidents reporting processes were appropriate.	
X	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.	Twelve months of Medical Records Committee meeting minutes reviewed: • The review of EHR quality did not include EHRs from Medicine or Surgery Services.
	The policy for scanning non-VA care documents met selected requirements.	

NM	Areas Reviewed (continued)	Findings
	The process to review blood/transfusions usage met selected requirements: • A committee with appropriate clinical membership met at least quarterly to review blood/transfusions usage. • Additional data elements were routinely reviewed.	
	Overall, if significant issues were identified, actions were taken and evaluated for effectiveness.	
	Overall, senior managers were involved in performance improvement over the past 12 months.	
	Overall, the facility had a comprehensive, effective QM/performance improvement program over the past 12 months.	
	The facility met any additional elements required by VHA or local policy.	

Recommendations

1. We recommended that processes be strengthened to ensure that code reviews include screening for clinical issues prior to the code that may have contributed to the occurrence of the code.

2. We recommended that the Surgical Invasive Procedure Committee includes the COS as a member, monitors surgery performance improvement activities, and documents its review of surgical deaths.

3. We recommended that processes be strengthened to ensure that the review of EHR quality includes most services.

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 emergency department, the CLC, the intensive care unit, the inpatient medical/surgical and MH units, primary care, audiology, and the x-ray and fluoroscopy areas. Additionally, we reviewed relevant documents, conversed with key employees and managers, and reviewed 25 employee training records (10 radiology employees, 10 MH unit employees, and 5 Multidisciplinary Safety Inspection Team members). 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 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.	
	Environmental safety requirements were met.	
	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.	
	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.	

NM	Areas Reviewed for Radiology (continued)	Findings
	The facility had 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.	
NA	MH unit staff, Multidisciplinary Safety Inspection Team members, and occasional unit workers received training on how to identify and correct environmental hazards, content and proper use of the MH EOC Checklist, and VA's National Center for Patient Safety study of suicide on psychiatric units.	
NA	The locked MH unit(s) was/were in compliance with MH EOC Checklist safety requirements or an abatement plan was in place.	
	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.	

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 33 randomly selected inpatients discharged on 1 of 3 selected oral antibiotics. The table below shows the areas reviewed for this topic. The area marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

NM	Areas Reviewed	Findings
	Clinicians conducted inpatient learning assessments within 24 hours of admission or earlier if required by local policy.	
X	If learning barriers were identified as part of the learning assessment, medication counseling was adjusted to accommodate the barrier(s).	• For the two patients with identified learning barriers, EHR documentation did not reflect medication counseling accommodation to address the barriers.
	Patient renal function was considered in fluoroquinolone dosage and frequency.	
	Providers completed discharge progress notes or discharge instructions, written instructions were provided to patients/caregivers, and EHR documentation reflected that the instructions were understood.	
	Patients/caregivers were provided a written medication list at discharge, and the information was consistent with the dosage and frequency ordered.	
	Patients/caregivers were offered medication counseling, and this was documented in patient EHRs.	
	The facility established a process for patients/caregivers regarding whom to notify in the event of an adverse medication event.	
	The facility complied with any additional elements required by VHA or local policy.	

Recommendation

4. 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 we conversed with key employees. Additionally, we reviewed the EHRs of 21 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
	Patients' post-discharge needs were identified, and discharge planning addressed the identified needs.	
X	Clinicians provided discharge instructions to patients and/or caregivers and validated their understanding.	• Eight patients' discharge instructions were not consistent with identified post-discharge needs. • Discharge instructions did not include all elements required by VHA policy, such as activity level.
	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.	
X	The facility complied with any additional elements required by VHA or local policy.	VHA and facility policy reviewed: • The facility did not have a Veterans Health Education Coordinator or an active Veterans Health Education Committee.

Recommendations

5. We recommended that processes be strengthened to ensure that discharge instructions are consistent with patients' identified post-discharge needs and include all elements required by VHA policy and that compliance be monitored.

6. We recommended that the facility have a Veterans Health Education Coordinator and an active Veterans Health Education Committee.

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 15 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 2MS, MH unit 2P, and the CLC—for 50 randomly selected days between October 1, 2012, and September 30, 2013. The table below shows the areas reviewed for this topic. 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 either implemented or reassessed a nurse staffing methodology within the expected timeframes.	
X	The facility expert panel followed the required processes and included the required members.	• The facility expert panel did not include a staff nurse, an Associate Nurse Executive, evening and night supervisory staff, or nurse managers from the various areas.
	The unit-based expert panels followed the required processes and included the required members.	
X	Members of the expert panels completed the required training.	• None of the six facility expert panel members had 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.	

Recommendations

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

8. We recommended that all members of the facility expert panel receive the required training prior to the next annual staffing plan reassessment.

Pressure Ulcer Prevention and Management

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

We reviewed relevant documents, 11 EHRs of patients with pressure ulcers (1 patient with a hospital-acquired pressure ulcer and 10 patients with community-acquired pressure ulcers), and 10 employee training records. The table below shows the areas reviewed for this topic. The areas marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

NM	Areas Reviewed	Findings
	The facility had a pressure ulcer prevention policy, and it addressed prevention for all inpatient areas and for outpatient care.	
	The facility had an interprofessional pressure ulcer committee, and the membership included a certified wound care specialist.	
X	Pressure ulcer data was analyzed and reported to facility executive leadership.	SCC meeting minutes for past 3 quarters reviewed: • Minutes did not reflect ongoing pressure ulcer data analysis. • Pressure ulcer data was not routinely reported to facility executive leadership.
	Complete skin assessments were performed within 24 hours of acute care admissions.	
	Skin inspections and risk scales were performed upon transfer, change in condition, and discharge.	
X	Staff were generally consistent in documenting location, stage, risk scale score, and date acquired.	• In 2 of the 11 EHRs, staff did not consistently document pressure ulcer location and stage.
	Required activities were performed for patients determined to be at risk for pressure ulcers and for patients with pressure ulcers.	
	Required activities were performed for patients determined to not be at risk for pressure ulcers.	
	For patients at risk for and with pressure ulcers, interprofessional treatment plans were developed, interventions were recommended, and EHR documentation reflected that interventions were provided.	
	If the patient's pressure ulcer was not healed at discharge, a wound care follow-up plan was documented, and the patient was provided appropriate dressing supplies.	

NM	Areas Reviewed (continued)	Findings
X	The facility defined requirements for patient and caregiver pressure ulcer education, and education on pressure ulcer prevention and development was provided to those at risk for and with pressure ulcers and/or their caregivers.	Facility pressure ulcer patient and caregiver education requirements reviewed: • For 2 of the 11 patients, EHRs did not contain evidence that education was provided.
X	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 had not developed requirements for ongoing staff pressure ulcer education.
NA	The facility complied with selected fire and environmental safety, infection prevention, and medication safety and security requirements in pressure ulcer patient rooms.	
	The facility complied with any additional elements required by VHA or local policy.	

Recommendations

9. We recommended that processes be strengthened to ensure that SCC minutes include analysis of pressure ulcer data and that the SCC routinely reports program data to facility executive leadership.

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

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

12. We recommended that the facility establish ongoing staff pressure ulcer education requirements and that compliance be monitored.

CLC Resident Independence and Dignity

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

We reviewed eight EHRs of residents (seven residents receiving restorative nursing services and one resident not receiving restorative nursing services but a candidate for services). We also observed 27 residents during 3 meal periods, reviewed 7 employee training/competency records and other relevant documents, and conversed with key employees. The table below shows the areas reviewed for this topic. The area marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

NM	Areas Reviewed	Findings
	The facility offered restorative nursing services.	
X	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.	• In 4 of the 7 applicable EHRs, documentation of facility staff completion of restorative nursing services according to clinician orders and/or residents' care plans or documentation of reasons for discontinuing or not providing restorative nursing services was missing more than 50 percent of the time.
	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.	

NM	Areas Reviewed for Assistive Eating Devices and Dining Service (continued)	Findings
	Required activities were performed during resident meal periods.	
	The facility complied with any additional elements required by VHA or local policy.	

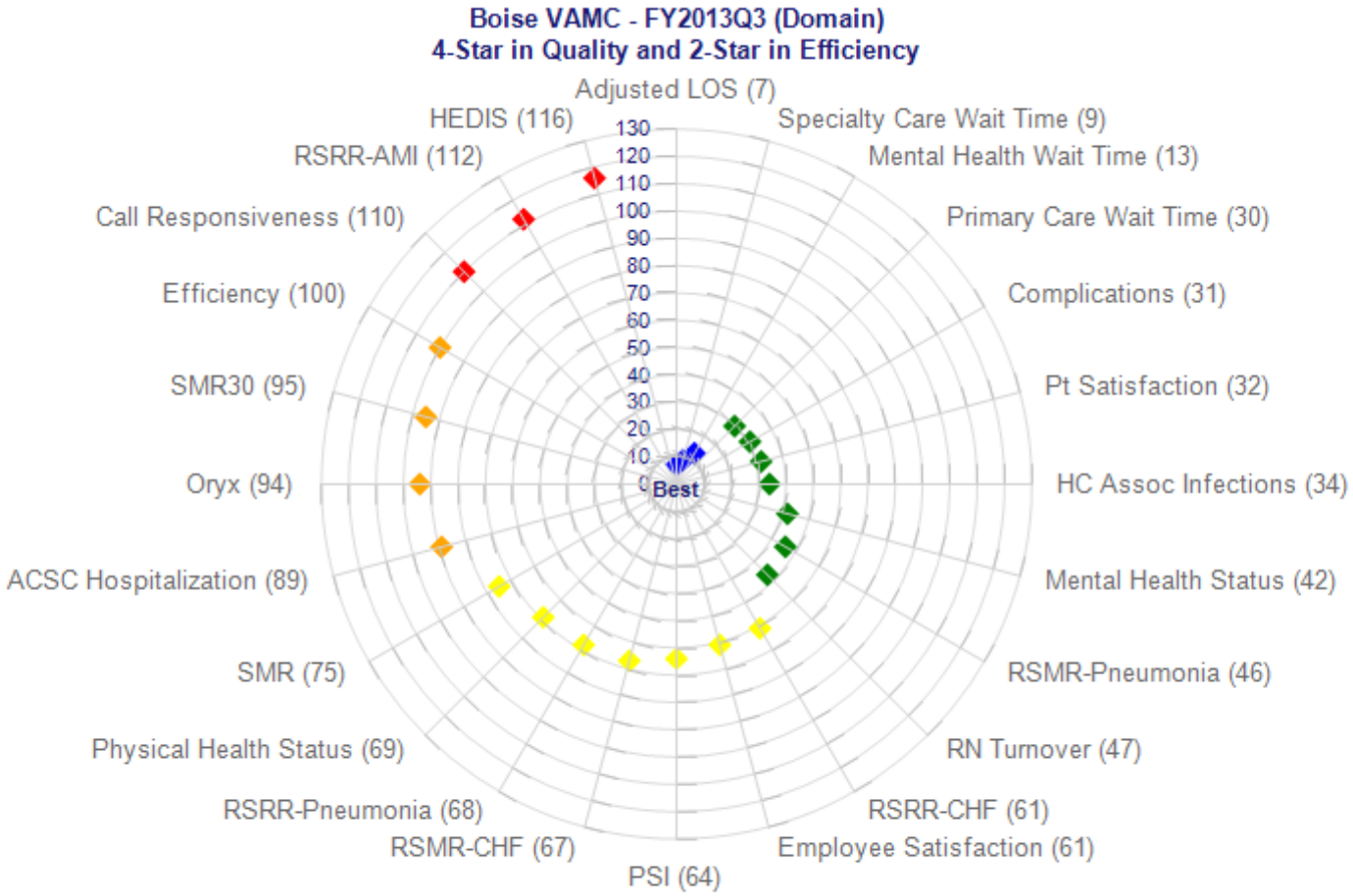
Recommendations

13. We recommended that processes be strengthened to ensure that staff complete and document restorative nursing services according to clinician orders and/or residents' care plans or document reasons for discontinuing or not providing restorative nursing services and that compliance be monitored.

Facility Profile (Boise/531) FY 2014 through December 2013[a]	
Type of Organization	Secondary
Complexity Level	2-Medium complexity
Affiliated/Non-Affiliated	Affiliated
Total Medical Care Budget in Millions (September 2013)	$195.4
Number of:	
• **Unique Patients**	18,030
• **Outpatient Visits**	76,584
• **Unique Employees**[b]	970
Type and Number of Operating Beds (November 2013):	
• **Hospital**	46
• **CLC**	28
• **MH**	11
Average Daily Census (November 2013):	
• **Hospital**	25
• **CLC**	23
• **MH**	8
Number of Community Based Outpatient Clinics	2
Location(s)/Station Number(s)	Twin Falls/531GE Canyon County/531GG
VISN Number	20

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

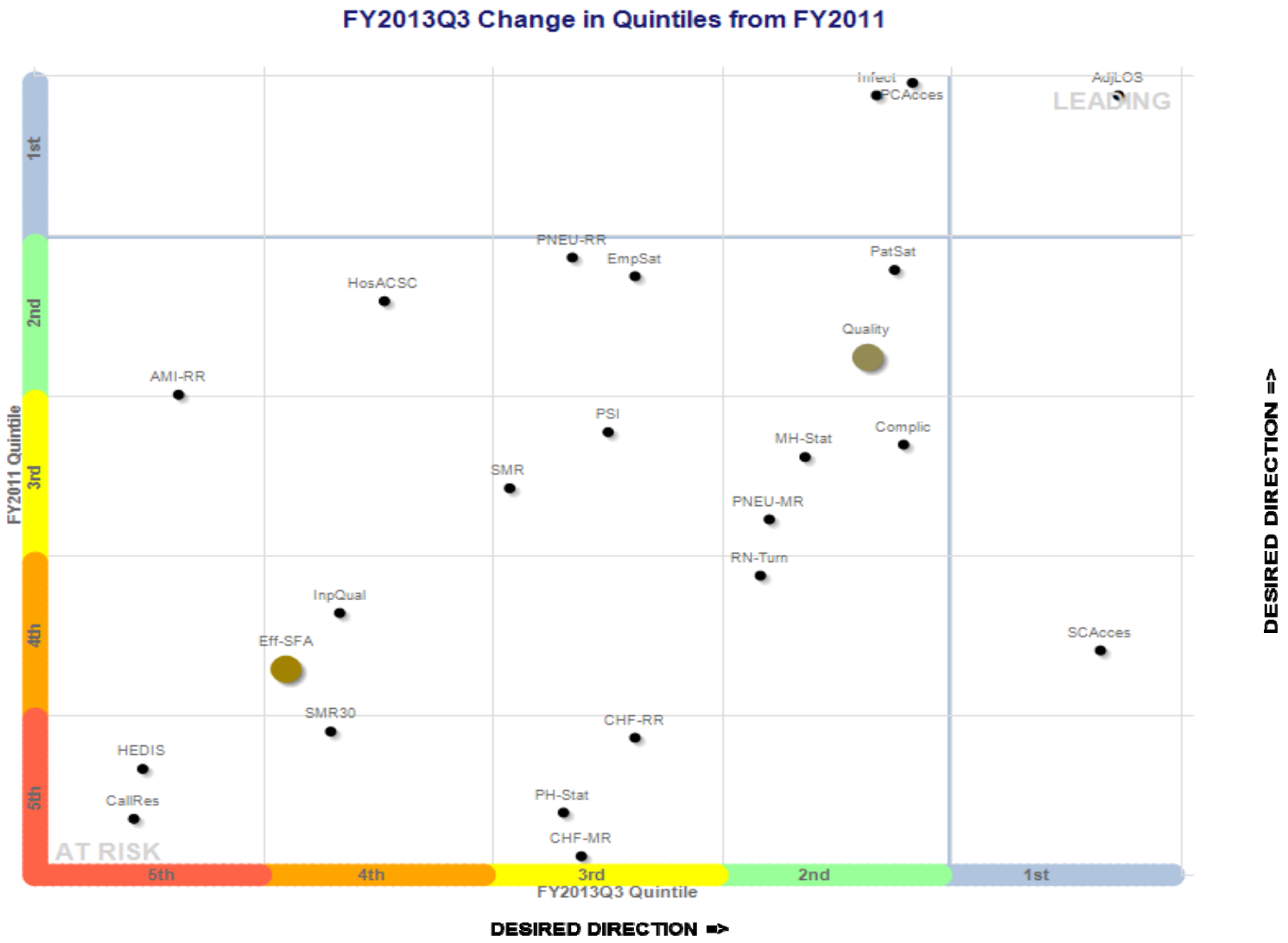
Strategic Analytics for Improvement and Learning (SAIL)[c]



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	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 31, 2014

From: Director, Northwest Network (10N20)

Subject: **CAP Review of the Boise VA Medical Center, Boise, ID**

To: Director, Seattle Office of Healthcare Inspections (54SE)

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

1. Thank you for the opportunity to respond to the proposed recommendations from the Combined Assessment Program Review at the Boise VA Medical Center, Boise, Idaho.

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 Susan Gilbert, Survey Coordinator, VISN 20 at (360) 567-4678.

(original signed by:)
Lawrence H. Carroll

Facility Director Comments

Department of Veterans Affairs **Memorandum**

Date: January 24, 2014

From: Director, Boise VA Medical Center (531/00)

Subject: **CAP Review of the Boise VA Medical Center, Boise, ID**

To: Director, Northwest Network (10N20)

1. Thank you for the opportunity to review the report on the Office of Inspector General Combined Assessment Program Review at the Boise VA Medical Center during the week of December 2, 2014. We concur with the findings and recommendations and will ensure that actions to correct them are completed as described.

2. Please find attached our facility responses to each recommendation, including the status of the corrective action plans.

3. If you have any additional questions or need further information, please contact Dr. Jean Anderson, Chief, Quality and Performance Improvement at 208-422-1105.

(original signed by:)
David Wood, MHA, FACHE
Director, Boise VA Medical Center

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 code reviews include screening for clinical issues prior to the code that may have contributed to the occurrence of the code.

Concur

Target date for completion: June 30, 2014

Facility Response: A compliant code blue review template was identified in existing written guidance and was used to update the facility MCM. The Critical Care and CPR (CC&CCR) committee's code screening process and its documentation in the minutes will be revised and implemented to ensure that pre-code clinical conditions are identified and analyzed for contributions to the occurrence of the code. Members of the Committee and applicable hospital staff have been educated on the updated review template, process, and revised MCM.

Compliance with screening for clinical issues prior to the code that may have contributed to the occurrence of the code will be monitored monthly. Monthly auditing results will be reported to the Clinical Executive Board.

Recommendation 2. We recommended that the Surgical Invasive Procedure Committee includes the COS as a member, monitors surgery performance improvement activities, and documents its review of surgical deaths.

Concur

Target date for completion: June 30, 2014

Facility Response: Facility and surgery service policies and processes have been updated to clarify and align the existing facility committees' names, membership, surgery quality improvement activities, and surgical death reviews with VHA Handbook 1102.01 requirements. Processes, tools, reporting, and documentation requirements for surgery quality improvement activities and review of surgical deaths will be updated and implemented to ensure compliance with VHA and facility guidance. Applicable staff will be educated on VHA and updated facility surgical program processes, tools, reporting, and documentation requirements. The chief of staff is responsible for assuring these changes are implemented and sustained.

Compliance with requirements to monitor surgery improvement activities and document review of surgical deaths will be monitored monthly. Monthly auditing results will be reported to the Clinical Executive Board.

Recommendation 3. We recommended that processes be strengthened to ensure that the review of EHR quality includes most services.

Concur

Target date for completion: June 30, 2014.

Facility response: Medical record review processes, tools, and reporting requirements for the medicine and surgery services will be updated and implemented to ensure compliance with VHA and facility guidance. Applicable medical and surgical staff will be educated on the medical record review and reporting requirements, and updated processes and tools. The chief of staff is responsible for assuring these changes are implemented and sustained.

Compliance with reviews of medicine and surgery medical record quality will be monitored quarterly. Quarterly auditing results will be reported to the Clinical Executive Board.

Recommendation 4. 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: June 30, 2014.

Facility response: The Medication Reconciliation Reminder template has been updated and implemented to ensure that accommodations to address identified learning barriers are implemented and documented. All clinicians conducting medication education will be educated on the updated template and the need to accommodate identified learning barriers and document appropriately.

Compliance with implementing and documenting accommodations to address identified learning barriers will be monitored monthly. Monthly auditing results will be reported to the Clinical Executive Board.

Recommendation 5. We recommended that processes be strengthened to ensure that discharge instructions are consistent with patients' identified post-discharge needs and include all elements required by VHA policy and that compliance be monitored.

Concur

Target date for completion: June 30, 2014.

Facility response: Discharge instruction processes, identified in the review, are being updated to ensure congruence between patients' identified post-discharge needs and all discharge instructions. Discharge Instructions templates are being updated to include all elements required by VHA policy. All applicable inpatient staff will be educated on the updated discharge instruction processes, discharge instruction requirements in VHA and facility policies, and the revised templates.

Compliance with requirements for discharge instructions to be consistent with patients' identified post-discharge needs and to include all elements mandated by VHA policy will be monitored monthly. Monthly auditing results will be reported to the Clinical Executive Board.

Recommendation 6. We recommended that the facility have a Veterans Health Education Coordinator and an active Veterans Health Education Committee.

Concur

Target date for completion: March 31, 2014

Facility Response: To build synergy and improve patient care outcomes across care settings, the Veterans Health Education Committee (VHEC) and Health Promotion Disease Prevention Committee (HPDP) will be combined, beginning January 2014. The newly combined committee is scheduled to meet monthly (at least 10 times per calendar year). Relevant facility MCMs have been updated. A new Functional Statement, merging the VHEC and HPDP coordinators' positions, was created. The new position will be filled by February 2014.

Compliance with the requirements to have a VHE Coordinator and an active VHEC will be monitored monthly. Monthly auditing results will be reported to the Administrative Executive Board.

Recommendation 7. We recommended that the annual staffing plan reassessment process ensures that the facility expert panel includes all required members.

Concur

Target date for completion: December 31, 2013

Facility Response: The facility expert panel membership was updated to include all required staff members.

Recommendation 8. We recommended that all members of the facility expert panel receive the required training prior to the next annual staffing plan reassessment.

Concur

Target date for completion: December 31, 2013

Facility Response: Required training was completed by all members of the facility expert panel and tracked in TMS. The Chief Nurse Executive or designee is responsible for assuring these changes are implemented and sustained.

Recommendation 9. We recommended that processes be strengthened to ensure that SCC minutes include analysis of pressure ulcer data and that the SCC routinely reports program data to facility executive leadership.

Concur

Target date for completion: November 30, 2014

Facility Response: The SCC developed and implemented a process to ensure that SCC minutes document the analysis of pressure ulcer data. Quarterly reporting of the SCC program data to the Clinical Executive Board (CEB) will be initiated February 2014 and reported quarterly, by the CEB, to the Executive Leadership Council.

Compliance with documentation of pressure ulcer data analysis in the SCC minutes and reporting of program data to executive leadership will be monitored quarterly. Quarterly auditing results will be reported to the Clinical Executive Board.

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

Concur

Target date for completion: November 30, 2014

Facility Response: Processes will be developed for the nurse analyst or designee to evaluate the accuracy of applicable acute care staff's documentation of pressure ulcers, including stage and location, and provide feedback to improve staff's documentation skills.

Compliance with accurate documentation of pressure ulcer location and stage for at least 90% of the acute care patients with pressure ulcers will be monitored quarterly. Auditing results will be reported quarterly to the Skin Care Council and the Clinical Executive Board.

Recommendation 11. We recommended that processes be strengthened to ensure that acute care staff provide and document pressure ulcer education for patients with pressure ulcers and/or their caregivers and that compliance be monitored.

Concur

Target date for completion: November 30, 2014

Facility Response: A pressure ulcer education process, educational materials, and a pressure ulcer patient education template will be created by a multidisciplinary team. Applicable acute care staff will be educated on the new pressure ulcer education process, materials, and template. The Skin Care Council is responsible for assuring these changes are implemented and sustained.

Compliance with documentation of pressure ulcer education for patients with pressure ulcers and/or their caregivers will be monitored quarterly. Auditing results will be reported quarterly to the Skin Care Council and the Clinical Executive Board.

Recommendation 12. We recommended that the facility establish ongoing staff pressure ulcer education requirements and that compliance be monitored.

Concur

Target date for completion: June 30, 2014

Facility Response: A written pressure ulcer education process for applicable acute care staff, consistent with VHA and facility guidance requirements, will be developed and implemented. Staff will be educated on the new pressure ulcer education requirement.

Compliance with establishing an on-going staff pressure education program will be monitored quarterly. Quarterly auditing results will be reported to the Skin Care Council and the Clinical Executive Board.

Recommendation 13. We recommended that processes be strengthened to ensure that staff complete and document restorative nursing services according to clinician orders and/or residents' care plans or document reasons for discontinuing or not providing restorative nursing services and that compliance be monitored.

Concur

Target date for completion: June 30, 2014

Facility Response: A templated note to document restorative nursing services, patient progress, discharge criteria, and the reason for any disruption to the restorative services has been developed and implemented. Written restorative nursing services procedures will be updated to ensure compliance with VHA and facility policies. Applicable CLC staff will be educated on the need to complete restorative nursing services according to clinician orders and/or residents' care plans, the updated procedures, and the new restorative nursing services note template

Compliance with requirements to complete and document restorative nursing services according to clinician orders and/or residents' care plans and document reasons for discontinuing or not providing restorative nursing service will be monitored monthly. Monthly auditing results will be reported to the Clinical Executive Board.

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Endnotes

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