Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 14-00308-105

Combined Assessment Program Review of the Overton Brooks VA Medical Center Shreveport, Louisiana

March 31, 2014

Washington, DC 20420

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

Glossary

CAP	Combined Assessment Program
EHR	electronic health record
EOC	environment of care
facility	Overton Brooks VA Medical Center
FY	fiscal year
MEC	Medical Executive Committee
MH	mental health
NA	not applicable
NM	not met
OIG	Office of Inspector General
PRC	Peer Review Committee
QM	quality management
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

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Executive Summary

Review Purpose: The purpose of the review was to evaluate selected health care facility operations, focusing on patient care quality and the environment of care, and to provide crime awareness briefings. We conducted the review the week of January 27, 2014.

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

- Medication Management
- Coordination of Care

Recommendations: We made recommendations in the following four activities:

Quality Management: Reassess observation criteria and utilization when conversions from observation bed status to acute admissions are over 30 percent. Perform continuing stay reviews on at least 75 percent of patients in acute beds. Include a clinical representative from Surgery Service on the Blood Utilization Review Committee. Ensure that corrective actions are initiated and/or consistently followed to resolution when data analyses indicated problems or opportunities for improvement in the Performance Improvement, Medical Executive, and Executive Safety Committees.

Environment of Care: Ensure patient care areas and restrooms are clean. Repair holes in the walls, and monitor ongoing maintenance. Ensure all locked mental health unit staff and occasional locked mental health unit workers receive training on identifying and correcting environmental hazards, proper use of the Mental Health Environment of Care Checklist, and VA's National Center for Patient Safety study of suicide on psychiatric units.

Nurse Staffing: Include all required members on unit 6E's and unit 9E's unit-based expert panels.

Pressure Ulcer Prevention and Management: Include data analysis in Interprofessional Skin Integrity Committee minutes. Accurately document location, stage, and risk scale score 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.

Comments

The Veterans Integrated Service Network Director and Interim Facility Director agreed with the Combined Assessment Program review findings and recommendations and provided acceptable improvement plans. (See Appendixes C and D, pages 18–24, 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
- Pressure Ulcer 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 2012, FY 2013, and FY 2014 through January 24, 2014, 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 Overton Brooks VA Medical Center, Shreveport, Louisiana, Report No. 10-00048-118, March 29, 2010).

During this review, we presented crime awareness briefings for 253 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 79 responded. We shared summarized results with facility managers.

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

Results and Recommendations

QM

The purpose of this review was to determine whether facility senior managers actively supported and appropriately responded to QM efforts and whether the facility met selected requirements within its QM program.[1]

We conversed with senior managers and key QM employees, and we evaluated meeting minutes, EHRs, and other relevant documents. The table below shows the areas reviewed for this topic. The areas marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

NM	Areas Reviewed	Findings
	There was a senior-level committee/group responsible for QM/performance improvement that met regularly. • There was evidence that outlier data was acted upon. • There was evidence that QM, patient safety, and systems redesign were integrated.	
	The protected peer review process met selected requirements: • The PRC was chaired by the Chief of Staff and included membership by applicable service chiefs. • Actions from individual peer reviews were completed and reported to the PRC. • The PRC submitted quarterly summary reports to the MEC. • Unusual findings or patterns were discussed at the MEC.	
	Focused Professional Practice Evaluations for newly hired licensed independent practitioners were initiated and completed, and results were reported to the MEC.	
NA	Specific telemedicine services met selected requirements: • Services were properly approved. • Services were provided and/or received by appropriately privileged staff. • Professional practice evaluation information was available for review.	

NM	Areas Reviewed (continued)	Findings
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 reassessed timely.	Eleven months of data reviewed: • For January–November 2013, 41 percent of observation patients were converted to acute admissions, and the facility had not reassessed observation criteria or utilization during that time.
X	Staff performed continuing stay reviews on at least 75 percent of patients in acute beds.	Eleven months of continuing stay data reviewed: • For all months, less than 75 percent of acute inpatients were reviewed.
	The process to review resuscitation events met selected requirements: • An interdisciplinary committee was responsible for reviewing episodes of care where resuscitation was attempted. • Resuscitation event reviews included screening for clinical issues prior to events that may have contributed to the occurrence of the code. • Data were collected that measured performance in responding to events.	
	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.	Twelve months of Blood Utilization Review Committee meeting minutes reviewed: • There was no clinical representative from Surgery Service on the committee.
X	Overall, if significant issues were identified, actions were taken and evaluated for effectiveness.	• Corrective actions were not consistently initiated and/or followed to resolution in the Performance Improvement Committee and MEC.
	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 when conversions from observation bed status to acute admissions are over 30 percent, observation criteria and utilization are reassessed.

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

3. We recommended that the Blood Utilization Review Committee include a clinical representative from Surgery Service.

4. We recommended that processes be strengthened to ensure that corrective actions are initiated and/or consistently followed to resolution when data analyses indicated problems or opportunities for improvement in the Performance Improvement, Medical Executive, and Executive Safety Committees.

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 intensive care, medicine, surgery, and acute MH units; the emergency department; primary care and specialty care clinics; and the general radiology and fluoroscopy areas. Additionally, we reviewed relevant documents, conversed with key employees and managers, and reviewed 30 employee training records (10 radiology employees, 11 acute MH unit employees, 4 Multidisciplinary Safety Inspection Team members, and 5 occasional acute MH unit employees). The table below shows the areas reviewed for this topic. The areas marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

NM	Areas Reviewed for General EOC	Findings
X	EOC Committee minutes reflected sufficient detail regarding identified deficiencies, corrective actions taken, and tracking of corrective actions to closure.	Seven months of Executive Safety Committee meeting minutes reviewed: • Minutes did not reflect that corrective actions were initiated when data analyses indicated problems or opportunities for improvement. (See recommendation 4 in QM.)
	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.	• Floors and baseboards in five of six patient care areas were not clean. • Inpatient bathrooms on two of the three units and public restrooms in three areas were not clean. • Supply and linen closets on one unit had multiple holes in the walls.
	Infection prevention requirements were met.	
	Medication safety and security requirements were met.	
	Auditory privacy requirements were met.	
	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.	

NM	Areas Reviewed for Radiology	Findings
	The facility had a Radiation Safety Committee, the committee met at least every 6 months and established a quorum for meetings, and the Radiation Safety Officer attended meetings.	
	Radiation Safety Committee meeting minutes reflected discussion of any problematic areas, corrective actions taken, and tracking of corrective actions to closure.	
	Facility policy addressed frequencies of equipment inspection, testing, and maintenance.	
	The facility had a policy for the safe use of fluoroscopic equipment.	
	The facility Director appointed a Radiation Safety Officer to direct the radiation safety program.	
	X-ray and fluoroscopy equipment items were tested by a qualified medical physicist before placed in service and annually thereafter, and quality control was conducted on fluoroscopy equipment in accordance with facility policy/procedure.	
	Designated employees received initial radiation safety training and training thereafter with the frequency required by local policy, and radiation exposure monitoring was completed for employees within the past year.	
	Environmental safety requirements in x-ray and fluoroscopy were met.	
	Infection prevention requirements in x-ray and fluoroscopy were met.	
	Medication safety and security requirements in x-ray and fluoroscopy were met.	
	Sensitive patient information in x-ray and fluoroscopy was protected.	
X	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.	• Floors/baseboards in the hallway and in the supply room containing contrast agents and the crash cart were not clean. • Walls in the supply room were in need of repair.
	Areas Reviewed for Acute MH	
	MH EOC inspections were conducted every 6 months.	
	Corrective actions were taken for environmental hazards identified during inspections, and actions were tracked to closure.	

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

Recommendations

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

6. We recommended that processes be strengthened to ensure that holes in the walls are repaired and that ongoing maintenance be monitored.

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

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 31 randomly selected inpatients discharged on 1 of 3 selected oral antibiotics. The table below shows the areas reviewed for this topic. Any items that did not apply to this facility are marked NA. The facility generally met requirements. We made no recommendations.

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

Coordination of Care

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

We reviewed relevant documents and conversed with key employees. Additionally, we reviewed the EHRs of 25 patients with specific diagnoses who were discharged from July 1, 2012, through June 30, 2013. The table below shows the areas reviewed for this topic. Any items that did not apply to this facility are marked NA. The facility generally met requirements. We made no recommendations.

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

Nurse Staffing

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

We reviewed facility and unit-based expert panel documents and 22 training files, and we conversed with key employees. Additionally, we reviewed the actual nursing hours per patient day for two randomly selected units—acute medical/surgical unit 6E and MH unit 9E—for 50 randomly selected days between October 1, 2012, and September 30, 2013. The table below shows the areas reviewed for this topic. The area marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

NM	Areas Reviewed	Findings
	The facility either implemented or reassessed a nurse staffing methodology within the expected timeframes.	
	The facility expert panel followed the required processes and included the required members.	
X	The unit-based expert panels followed the required processes and included the required members.	• The unit-based expert panels did not include licensed practical nurses or nursing assistants.
	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

8. We recommended that the annual staffing plan reassessment process ensures that unit 6E's and unit 9E's unit-based expert panels include all required members.

Pressure Ulcer Prevention and Management

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

We reviewed relevant documents, 13 EHRs of patients with pressure ulcers (10 patients with community-acquired pressure ulcers and 3 patients with pressure ulcers at the time of our onsite visit), and 10 employee training records. Additionally, we inspected two patient rooms. 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.	Minutes of Interprofessional Skin Integrity Committee for past 11 months reviewed: • Minutes did not reflect pressure ulcer data analysis.
	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 8 of the 13 EHRs, staff did not consistently document the location, stage, and/or risk scale score.
	Required activities were performed for patients determined to be at risk for pressure ulcers and for patients with pressure ulcers.	
NA	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 five of the applicable nine patients at risk for and with a pressure ulcer, EHRs did not contain evidence that education was provided.
	The facility defined requirements for staff pressure ulcer education, and acute care staff received training on how to administer the pressure ulcer risk scale, conduct the complete skin assessment, and accurately document findings.	
	The facility complied with selected fire and environmental safety, infection prevention, and medication safety and security requirements in pressure ulcer patient rooms.	
	The facility complied with any additional elements required by VHA or local policy.	

Recommendations

9. We recommended that processes be strengthened to ensure that Interprofessional Skin Integrity Committee minutes include data analysis.

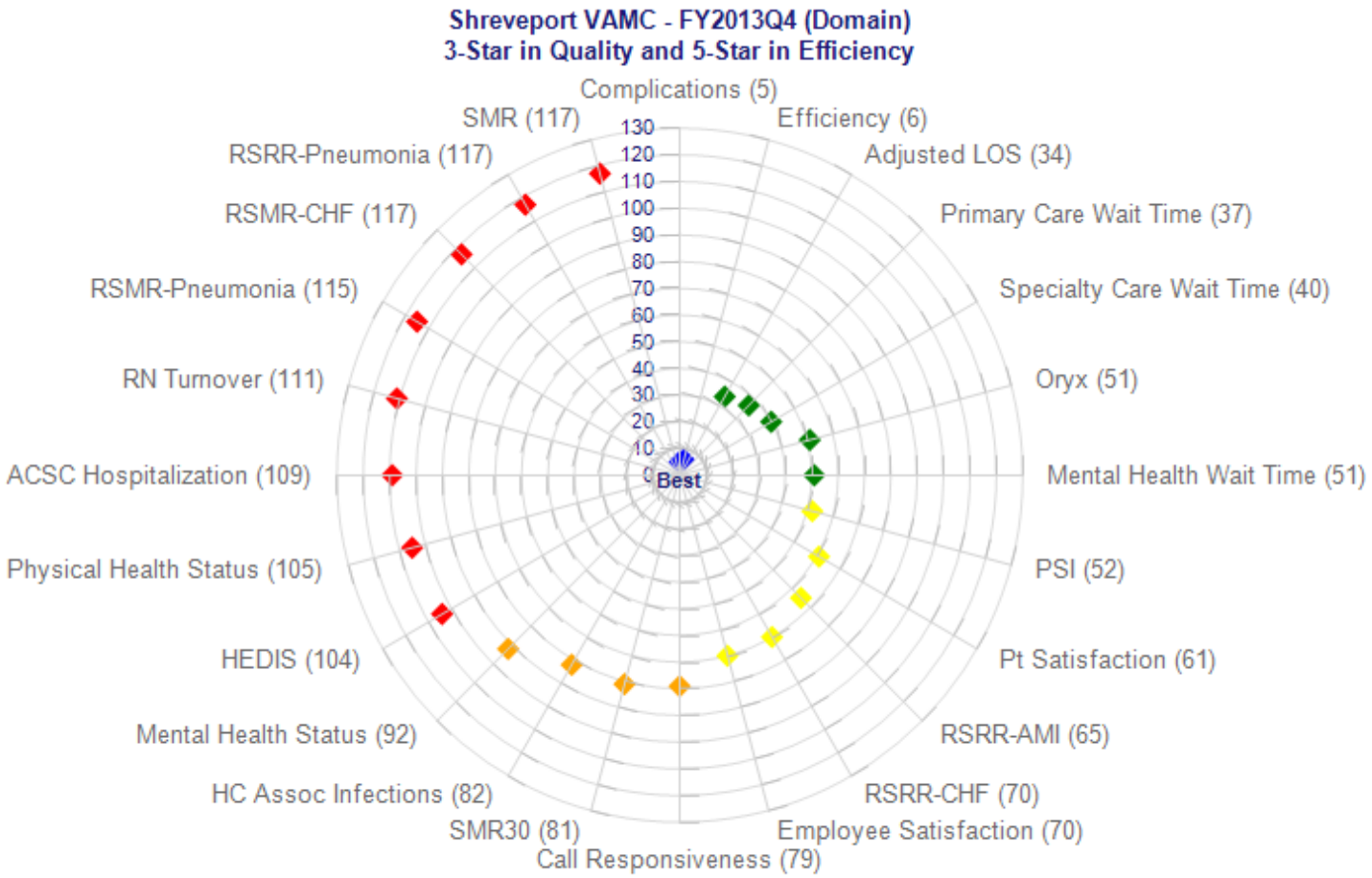
10. We recommended that processes be strengthened to ensure that acute care staff accurately document location, stage, and risk scale score for all patients with pressure ulcers and that compliance be monitored.

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

Facility Profile (Shreveport/667) FY 2014 through February 2014[a]	
Type of Organization	Secondary
Complexity Level	1c-High complexity
Affiliated/Non-Affiliated	Affiliated
Total Medical Care Budget in Millions	$273
Number of:	
• **Unique Patients**	27,754
• **Outpatient Visits**	149,280
• **Unique Employees**[b]	1,327
Type and Number of Operating Beds (December 2013):	
• **Hospital**	111
• **Community Living Center**	N/A
• **MH**	19
Average Daily Census (January 2014):	
• **Hospital**	77
• **Community Living Center**	N/A
• **MH**	10.8
Number of Community Based Outpatient Clinics	3
Location(s)/Station Number(s)	Texarkana/667GA Monroe/667GB Longview/667GC
VISN Number	16

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

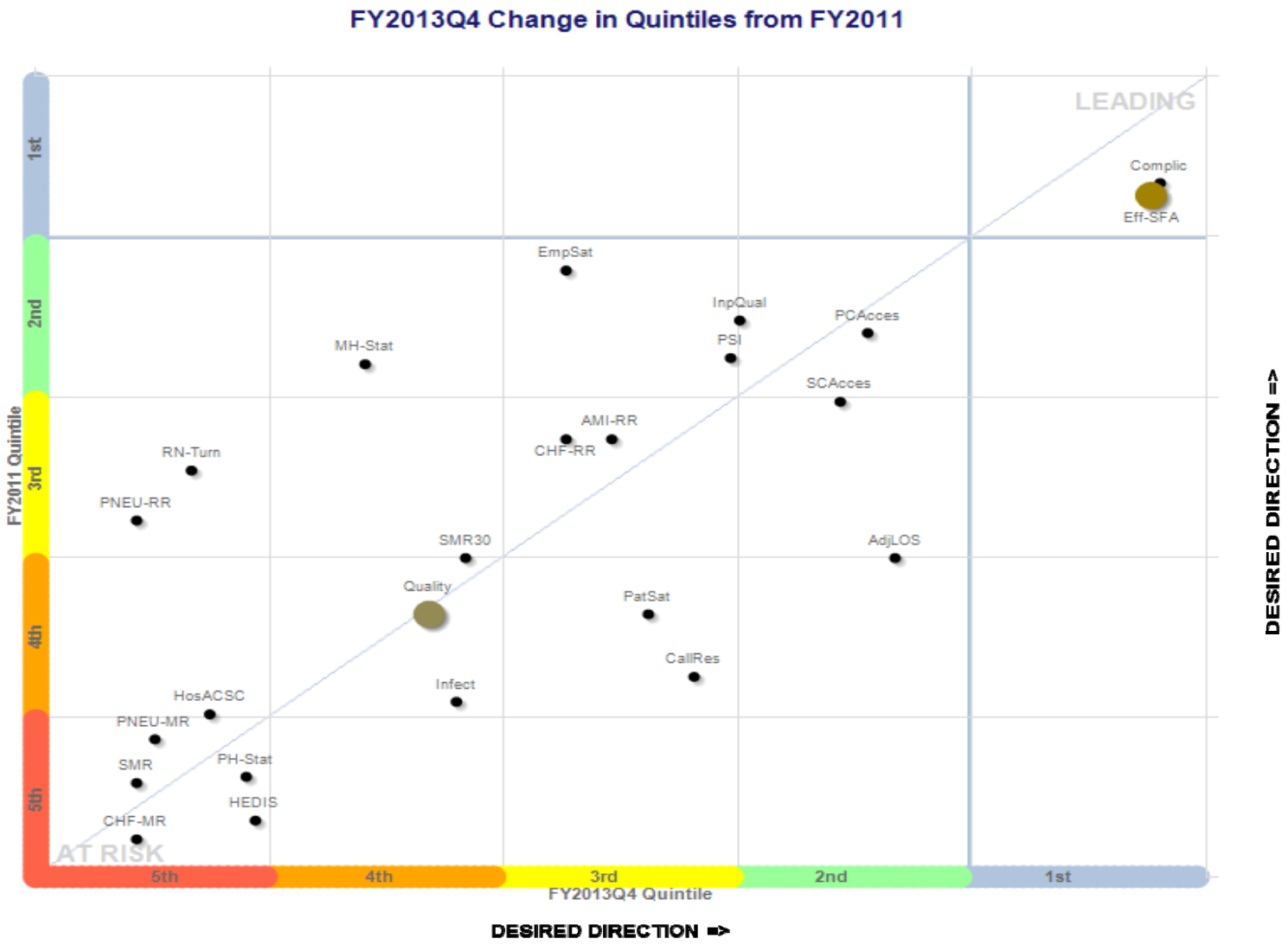
Strategic Analytics for Improvement and Learning (SAIL)[c]



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: March 18, 2014

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

Subject: **CAP Review of the Overton Brooks VA Medical Center, Shreveport, LA**

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

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

1. The South Central VA Health Care Network (VISN 16) has reviewed and concurs with the Combined Assessment Program (CAP) Review draft report submitted by the Overton Brooks VA Medical Center, Shreveport, LA.

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

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

Interim Facility Director Comments

Department of Veterans Affairs **Memorandum**

Date: March 17, 2014

From: Interim Director, Overton Brooks VA Medical Center (667/00)

Subject: **CAP Review of the Overton Brooks VA Medical Center, Shreveport, LA**

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

1. The Overton Brooks VA Medical Center, Shreveport, LA, concurs with the findings in the OIG CAP Review of the Overton Brooks VA Medical Center, Shreveport, LA.

2. If you have any questions or need additional information, please contact Myrtle Tate, Quality Management Consultant at (318) 990-5407.

Mark A. Enderle, MD
Interim Medical Center Director, Overton Brooks VA Medical Center (667/00)

Comments to OIG's Report

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

OIG Recommendations

Recommendation 1. We recommended that processes be strengthened to ensure that when conversions from observation bed status to acute admissions are over 30 percent, observation criteria and utilization are reassessed.

Concur

Target date for completion: April 1, 2014

Facility response:

- Utilization Management (UM) Case Managers are using McKesson InterQual® observation criteria upon admission to observation. Upon conversion from observation to another level of care, McKesson InterQual® criteria are again utilized to determine the most appropriate level of care.
- UM Case Managers interact daily with the Interdisciplinary Team to facilitate patient flow from observation to the appropriate level of care and to identify and address barriers that impact the observation conversion rate.
- Observation utilization/trends, including cases that do not meet observation criteria, will be reported monthly to the Performance Improvement Committee and at least quarterly to the Medical Staff Executive Committee to ensure corrective action is implemented and sustained.
- The observation conversion rate went down from 51% in December 2013 to 30% in February 2014. We will continue to track and reassess appropriateness of observation status utilizing McKesson InterQual® Criteria.

Recommendation 2. We recommended that processes be strengthened to ensure that continuing stay reviews are performed on at least 75 percent of patients in acute beds.

Concur

Target date for completion: July 1, 2014

Facility response: Actions to correct this finding include benchmarking with similar facilities for strategies to improve continued stay review percentages and assessing the workflow structure of the UM/Consult Management (CM) staff to identify other opportunities to improve efficiencies in continued stay reviews.

Continued stay review data will be presented monthly to the Performance Improvement Committee. The target of 75% will be sustained for a minimum of three consecutive months. The Performance Improvement Committee will track and take corrective action on an ongoing basis.

Recommendation 3. We recommended that the Blood Utilization Review Committee include a clinical representative from Surgery Service.

Concur

Target date for completion: February 2014

Facility response: Dr. [name withheld], General Surgery was named to the Transfusion Committee to represent Clinical Surgical Service. Dr. [name withheld] represents Anesthesia. The Quality Management Department will monitor attendance of the Blood Utilization Review Committee for six months to ensure participation by the Surgery Service Representative. The Chair, Blood Utilization Committee is responsible for monitoring meeting attendance on an ongoing basis.

Recommendation 4. We recommended that processes be strengthened to ensure that corrective actions are initiated and/or consistently followed to resolution when data analyses indicated problems or opportunities for improvement in the Performance Improvement, Medical Executive, and Executive Safety Committees.

Concur

Target date for completion: May 15, 2014

Facility response: The Chief, Quality Management will provide training to the Chairs of the Performance Improvement, Medical Staff, and Executive Safety Committee on how to analyze data to identify opportunities for improvement. When data analyses indicate problems or opportunities for improvement, the committee chair is responsible for documentation and tracking in minutes. The template for the minutes, Policy OOQM-14, "Minutes of Services, Committee and Board Meetings" facilitates tracking problems and opportunities until closure. The minutes will be audited monthly by Quality Management for three consecutive months to ensure that problems are tracked until closure and reported to the Performance Improvement Committee. The chairs of the committees are responsible for ongoing compliance.

In addition, to strengthen the process for the Executive Safety Committee, the following actions were implemented: a. a new charter was developed; b. the agenda format was changed to allow for better tracking of items monthly; and, c. placed an emphasis with plan managers on reporting and evaluating actions taken on performance goals. Specifically, plan managers will need to use data to drive the resolutions and performance improvement.

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

Concur

Target date for completion: April 7, 2014

Facility response: The Chief of Environmental Services (EMS) developed an action plan which includes the following:

- Develop a daily inpatient room cleaning check off sheet.
- Develop a discharge cleaning log that will be distributed to all Housekeeping Supervisors.
- Develop a weekly cleaning schedule for all listed areas.
- Track the cleaning of housekeeping closets; storage, soiled utility, and medication rooms.
- Develop a well define training program for EMS staff (including supervisors).
- Conduct a staffing analysis, utilizing formats set up by VACO.

Findings from the Environment of Care (EOC) rounds related to cleanliness will be tracked monthly in the Executive Safety Committee. The committee will take appropriate action and ensure closure.

Recommendation 6. We recommended that processes be strengthened to ensure that holes in the walls are repaired and that ongoing maintenance be monitored.

Concur

Target date for completion: April 17, 2014

Facility response: Engineering Service will review all areas for general maintenance deficiencies and correct any deficiencies identified. Staff will be educated on the work order process and reporting requirements. Education will be conducted during initial reviews and by e-mail.

Engineering Service will perform ongoing in-house inspections, one area per week, and issue work orders to correct any deficiencies identified.

General maintenance will be tracked on weekly EOC rounds and through in-house inspections. General maintenance concerns will be discussed during Engineering staff meetings and reported quarterly to the Executive Safety Committee.

Deficiencies greater than 14 days will be tracked using an electronic spreadsheet and reported as part of regular EOC Reporting to the Executive Safety Committee.

Recommendation 7. We recommended that processes be strengthened to ensure that all locked MH unit staff and occasional locked MH unit workers receive training on how to identify and correct environmental hazards, proper use of the MH EOC Checklist, and VA's National Center for Patient Safety study of suicide on psychiatric units and that compliance be monitored.

Concur

Target date for completion: April 30, 2014

Facility response: All employees assigned to the locked MH unit as well as occasional MH unit workers will be trained on: (a) the process to identify and correct environmental hazards, (b) proper use of the MH EOC checklist, and (c) VA's National Center for Patient Safety study of suicide on psychiatric units. The MH EOC Checklist Training (Talent Management System 1290945 for clinical staff and 1290950 for non-clinical staff) will be added as annual training for staff who are assigned to the locked MH unit and occasional MH unit workers. Service Chiefs are responsible for ensuring documentation of the training in the Talent Management System (TMS). The Executive Safety Committee will monitor annual training compliance.

Recommendation 8. We recommended that the annual staffing plan reassessment process ensures that unit 6E's and unit 9E's unit-based expert panels include all required members.

Concur

Target date for completion: May 30, 2014

Facility response: The Deputy Associate Director for Patient Care Services will ensure that all required staff from 6E and 9E are added to the Unit Based Staffing Methodology panel, have the appropriate training, and are active participants during the May 2014 staffing methodology training. Since the OIG visit, one Licensed Practical Nurse (LPN) from 6E was added to the Unit Based Staffing Methodology panel; other staff will be appointed. Nursing Service will review the staffing plan annually, ensuring that panels are diverse in representation of each unit. The annual report will be submitted to the Clinical Leadership Board.

Recommendation 9. We recommended that processes be strengthened to ensure that Interprofessional Skin Integrity Committee minutes include data analysis.

Concur

Target date for completion: June 30, 2014

Facility response: The Wound Ostomy and Continence Nurse (WOCN) currently aggregate the data for initial skin assessment and reassessment. The WOCN develops and trends the data that is analyzed by the committee. The committee determines appropriate corrective action. The Inter-professional Skin Integrity Committee minutes

will be audited by Quality Management staff for three months to verify the analysis of data by the Committee. The report of the audit will be submitted to the Performance Improvement Committee. The chair of the Inter-professional Skin Integrity Committee is responsible for compliance.

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

Concur

Target date for completion: June 30, 2014

Facility response: Real time chart reviews and physical assessment are conducted daily by the WOCN on all patients with hospital and community acquired pressure ulcers. This process was implemented February 26, 2014. Chart reviews include documentation of the location, stage, and risk scale score. Findings are reported daily to Nurse Managers and Nursing Leadership. One-to-one education is provided to staff Registered Nurses (RNs) when incorrect documentation is identified. Braden Scale Training has been added to the facility's educational system known as Talent Management System (TMS) to reinforce appropriate assessment and documentation by the nursing staff. We will review all pressure ulcer cases until 90% accuracy is achieved on documentation of location, stage, and risk scale score.

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

Concur

Target date for completion: June 30, 2014

Facility response: Pressure ulcer education has been added to the medical records template to facilitate documentation. The WOCN conducts daily chart reviews on at-risk patients as well as patients with pressure ulcer for appropriate documentation of pressure ulcer education. Findings from the chart reviews on pressure ulcer education will be reported to the Interprofessional Skin Committee and the Clinical Leadership Board. A sample of 20 cases per month will be reviewed until 90% performance is achieved for three consecutive months. The performance report will be submitted to the Performance Improvement Committee.

OIG Contact and Staff Acknowledgments

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

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Endnotes

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