Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 14-00309-118

Combined Assessment Program Review of the Portland VA Medical Center Portland, Oregon

April 9, 2014

Washington, DC 20420

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

Glossary

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

Table of Contents

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 seven activities. The facility's reported accomplishments were its Homeless Program and recognition as a Joint Commission top performer.

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

Quality Management: Ensure that the Operative Care Division Quality and Performance Group meets monthly, includes the Chief of Staff as a member, and documents its review of National Surgical Office reports. Track and review all surgical deaths.

Environment of Care: Alarm all emergency exits on the locked mental health unit. Ensure panic alarm testing on the locked mental health unit includes VA Police response time.

Medication Management: Ensure that patient learning assessments are documented within 24 hours of admission and that clinicians conducting medication counseling accommodate identified learning barriers and document the accommodations made to address those barriers.

Coordination of Care: Ensure patients receive ordered aftercare services and/or items within the expected timeframe. Require the facility to have a Veteran Health Education Coordinator.

Nurse Staffing: Monitor the staffing methodology that was implemented in June 2013. Ensure all expert panel members receive the required training prior to the next annual staffing plan reassessment.

Pressure Ulcer Prevention and Management: Document pressure ulcer stage, and consistently document required pressure ulcer information. Ensure all patients discharged with pressure ulcers have wound care follow-up plans and receive dressing supplies prior to being discharged. Provide and document pressure ulcer education for patients with pressure ulcers and/or their caregivers. Establish staff pressure ulcer education requirements.

Community Living Center Resident Independence and Dignity: Document resident progress towards restorative nursing goals.

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 20–26, for the full text of the Directors' comments.) We consider recommendation 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 January 28, 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 Portland VA Medical Center, Portland, Oregon,* Report No. 10-01523-200, July 21, 2010).

During this review, we presented crime awareness briefings for 294 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 629 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 Accomplishments

Homeless Program

The facility's Homeless Program includes several services that are designed to address the needs of chronically homeless veterans, currently homeless veterans, and veterans who are at risk of becoming homeless. The program has a SharePoint site for all employees to ensure knowledge of resources and access to all of the facility's homeless services. Program entry is through the Community Resource and Referral Center. The Community Resource and Referral Center is a one-stop shop for community partners, internal customers, and veterans and provides a consistent and streamlined process.

Community partners donated funds to help obtain housing vouchers during FY 2013. Between 2011 and March of 2013, the facility's Homeless Program was able to successfully house 100 veterans. Due to these efforts, the program received both an award from Portland's mayor and a Coordinating Committee to End Homelessness Achievement Award. Additionally, the facility is a finalist for an award in the Community Partnership Challenge for work done with the Portland community and Operation 305 (a Portland Housing Bureau program).

Joint Commission Recognition

The facility was recognized 2 years in a row as a top performer among Joint Commission-accredited hospitals for a significant achievement in accountability and performance measures. Only 9 VA facilities have been rated as top performers for 2 consecutive years. The facility achieved a top rating in all four measures—heart attack, heart failure, pneumonia, and surgical care.

Results and Recommendations

QM

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

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

NM	Areas Reviewed	Findings
	There was a senior-level committee/group responsible for QM/performance improvement that met regularly. • There was evidence that outlier data was acted upon. • There was evidence that QM, patient safety, and systems redesign were integrated.	
	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.	
NA	Specific telemedicine services met selected requirements: • Services were properly approved. • Services were provided and/or received by appropriately privileged staff. • Professional practice evaluation information was available for review.	

NM	Areas Reviewed (continued)	Findings
	Observation bed use met selected requirements: • Local policy included necessary elements. • Data regarding appropriateness of observation bed usage was gathered. • If conversions to acute admissions were consistently 30 percent or more, observation criteria and utilization were reassessed timely.	
	Staff performed continuing stay reviews on at least 75 percent of patients in acute beds.	
	The process to review resuscitation events met selected requirements: • An interdisciplinary committee was responsible for reviewing episodes of care where resuscitation was attempted. • Resuscitation event reviews included screening for clinical issues prior to events that may have contributed to the occurrence of the code. • Data were collected that measured performance in responding to events.	
X	The surgical review process met selected requirements: • An interdisciplinary committee with appropriate leadership and clinical membership met monthly to review surgical processes and outcomes. • All surgical deaths were reviewed. • Additional data elements were routinely reviewed.	• The Operative Care Division Quality and Performance Group only met 6 times over the past 10 months. Six sets of Operative Care Division Quality and Performance Group meeting minutes reviewed: • The COS was not a member. • There was no evidence that National Surgical Office reports were reviewed. • The facility's process did not ensure that all surgical deaths were tracked and reviewed by appropriate clinical staff.
	Critical incidents reporting processes were appropriate.	
	The process to review the quality of entries in the EHR met selected requirements: • A committee was responsible to review EHR quality. • Data were collected and analyzed at least quarterly. • Reviews included data from most services and program areas.	
	The policy for scanning non-VA care documents met selected requirements.	

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

Recommendations

1. We recommended that the Operative Care Division Quality and Performance Group meet monthly, include the COS as a member, and document its review of National Surgical Office reports.

2. We recommended that processes be strengthened to ensure that all surgical deaths are tracked and reviewed by appropriate clinical staff.

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 acute MH unit, inpatient medical and surgical units, primary care, the eye clinic, and the x-ray and fluoroscopy units. Additionally, we reviewed relevant documents, conversed with key employees and managers, and reviewed 30 employee training records (10 radiology employees, 10 acute MH unit employees, 5 Multidisciplinary Safety Inspection Team members, and 5 occasional acute MH unit 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 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.	

NM	Areas Reviewed for Radiology (continued)	Findings
	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.	
	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.	

NM	Areas Reviewed for Acute MH (continued)	Findings
X	The locked MH unit(s) was/were in compliance with MH EOC Checklist safety requirements or an abatement plan was in place.	• Emergency exits were not alarmed. • Although panic alarm testing was conducted, VA Police response time was not documented for the past 2 months.
	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.	

Recommendations

3. We recommended that all emergency exits on the locked MH unit be alarmed.

4. We recommended that processes be strengthened to ensure that locked MH unit panic alarm testing includes VA Police response time 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. 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.	• For 5 of the 28 applicable patients, learning assessments were conducted more than 24 hours after admission.
X	If learning barriers were identified as part of the learning assessment, medication counseling was adjusted to accommodate the barrier(s).	• For two of the five 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.	

Recommendations

5. We recommended that processes be strengthened to ensure that patient learning assessments are documented within 24 hours of admission and that compliance be monitored.

6. We recommended that processes be strengthened to ensure that clinicians conducting medication counseling 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 32 randomly selected patients with specific diagnoses who were discharged from July 1, 2012, through June 30, 2013. The table below shows the areas reviewed for this topic. 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.	
	Clinicians provided discharge instructions to patients and/or caregivers and validated their understanding.	
X	Patients received the ordered aftercare services and/or items within the ordered/expected timeframe.	• Six (19 percent) patients did not receive the services and/or items ordered 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.

Recommendations

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

8. We recommended that the facility have a Veterans Health Education Coordinator.

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 47 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 9D, CLC unit E wing, and MH unit 5C—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
X	The facility either implemented or reassessed a nurse staffing methodology within the expected timeframes.	• Initial implementation was not completed until June 30, 2013.
	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.	
X	Members of the expert panels completed the required training.	• Four of the 32 (13 percent) members of the unit-based expert panels had not completed the required training. • Four of the 15 members of the facility expert panel had not 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

9. We recommended that nursing managers monitor the staffing methodology that was implemented in June 2013.

10. We recommended that all members of the facility and unit-based expert panels 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, 25 EHRs of patients with pressure ulcers (10 patients with hospital-acquired pressure ulcers, 10 patients with community-acquired pressure ulcers, and 5 patients with pressure ulcers at the time of our onsite visit), and 10 employee training records. Additionally, we inspected three patient rooms. The table below shows the areas reviewed for this topic. 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.	
	Pressure ulcer data was analyzed and reported to facility executive leadership.	
	Complete skin assessments were performed within 24 hours of acute care admissions.	
	Skin inspections and risk scales were performed upon transfer, change in condition, and discharge.	

X	Staff were generally consistent in documenting location, stage, risk scale score, and date acquired.	• In 3 of the 25 EHRs, staff did not document pressure ulcer stage.
		• In 10 of the 25 EHRs, staff were not consistent in documenting required pressure ulcer information. For example:
		  • For 1 patient, documentation regarding the presence of a pressure ulcer was missing for 4 consecutive days despite the patient having a previously identified stage II[a] ulcer.
		  • For six patients with current pressure ulcers, documentation indicated that the patients were not at risk for pressure ulcers and that the pressure ulcer protocol was not indicated. Because the protocol was not initiated, interventions were not identified.

	Required activities were performed for patients determined to be at risk for pressure ulcers and for patients with pressure ulcers.	

[a] A stage II ulcer is a partial thickness loss of skin that presents as a shallow open sore. It may also present as an intact or open fluid-filled blister.

NM	Areas Reviewed (continued)	Findings
	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.	
X	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.	• Three of the applicable four EHRs did not contain evidence of wound care follow-up plans at discharge. • Two of the applicable three EHRs did not contain evidence that patients received dressing supplies prior to discharge.
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 4 of the applicable 19 patients with a pressure ulcer, 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 staff pressure ulcer education requirements.
	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

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

12. We recommended that processes be strengthened to ensure that acute care staff consistently document required pressure ulcer information and that compliance be monitored.

13. We recommended that processes be strengthened to ensure that all patients discharged with pressure ulcers have wound care follow-up plans and receive dressing supplies prior to being discharged and that compliance be monitored.

14. 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.

15. We recommended that the facility establish 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 12 EHRs of residents (6 residents receiving restorative nursing services and 6 residents not receiving restorative nursing services but candidates for services). We also observed 37 residents during 2 meal periods, reviewed 10 employee training/competency records and other relevant documents, and conversed with key employees. The table below shows the areas reviewed for this topic. The area marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

NM	Areas Reviewed	Findings
	The facility offered restorative nursing services.	
	Facility staff completed and documented restorative nursing services, including active and passive range of motion, bed mobility, transfer, and walking activities, according to clinician orders and residents' care plans.	
X	Resident progress towards restorative nursing goals was documented, and interventions were modified as needed to promote the resident's accomplishment of goals.	• In two of the six applicable EHRs, there was no evidence that facility staff documented resident progress towards restorative nursing goals.
	When restorative nursing services were care planned but were not provided or were discontinued, reasons were documented in the EHR.	
	If residents were discharged from physical therapy, occupational therapy, or kinesiotherapy, there was hand-off communication between Physical Medicine and Rehabilitation Service and the CLC to ensure that restorative nursing services occurred.	
	Training and competency assessment were completed for staff who performed restorative nursing services.	
	The facility complied with any additional elements required by VHA or local policy.	
	Areas Reviewed for Assistive Eating Devices and Dining Service	
	Care planned/ordered assistive eating devices were provided to residents at meal times.	
	Required activities were performed during resident meal periods.	

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

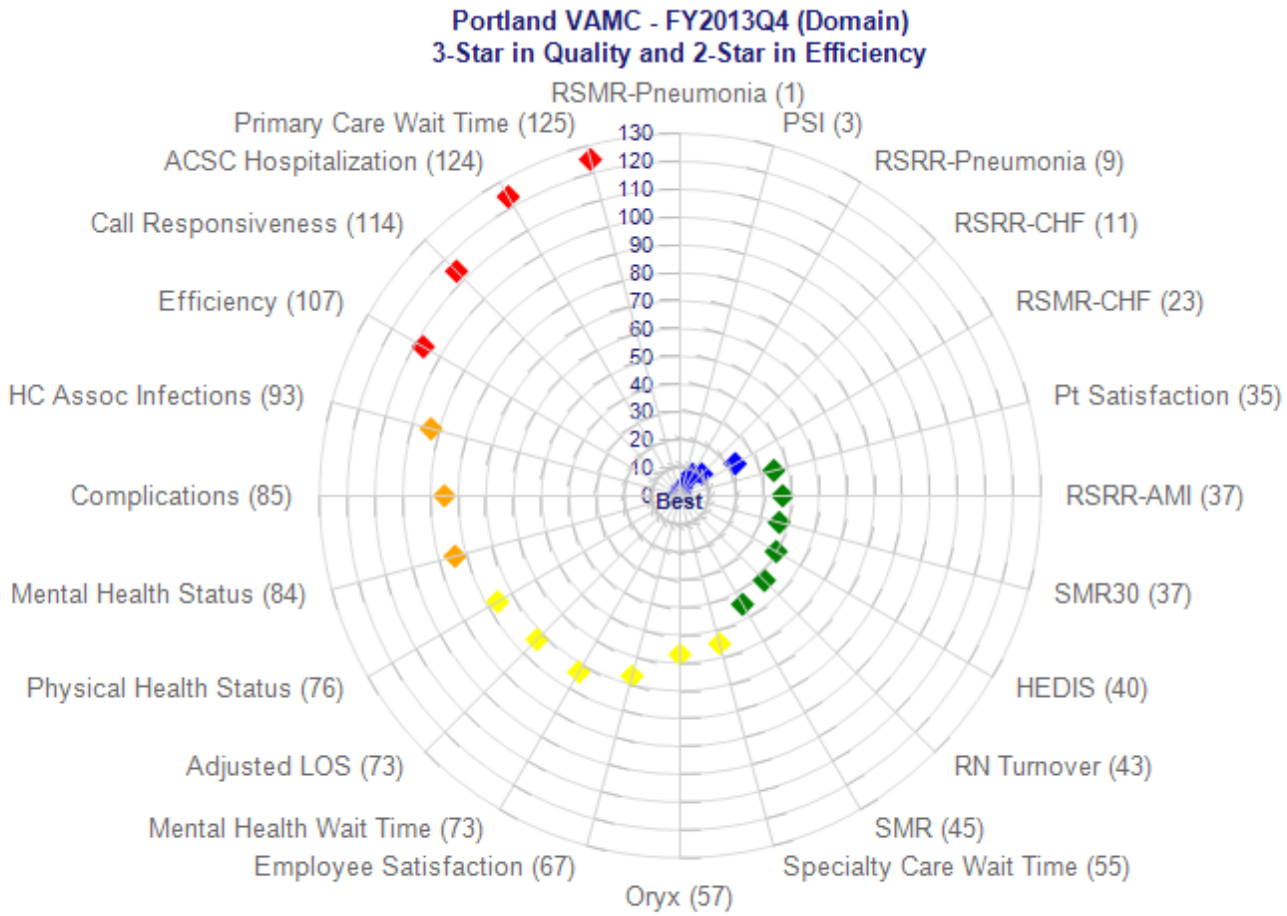
Recommendations

16. We recommended that processes be strengthened to ensure that staff document resident progress towards restorative nursing goals and that compliance be monitored.

Facility Profile (Portland/648) FY 2014 through February 2014[b]	
Type of Organization	Tertiary
Complexity Level	1a-High complexity
Affiliated/Non-Affiliated	Affiliated
Total Medical Care Budget in Millions	$580.2
Number of:	
• **Unique Patients**	61,557
• **Outpatient Visits**	311,036
• **Unique Employees**[c]	3,144
Type and Number of Operating Beds (December 2013):	
• **Hospital**	167
• **CLC**	72
• **MH**	28
Average Daily Census (January 2014):	
• **Hospital**	160
• **CLC**	70
• **MH**	26
Number of Community Based Outpatient Clinics	7
Location(s)/Station Number(s)	Vancouver/648A4 Bend/648GA Salem/648GB North Coast/648GD East Metro Portland/648GE West Metro Portland/G48GF West Linn/648GG
VISN Number	20

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

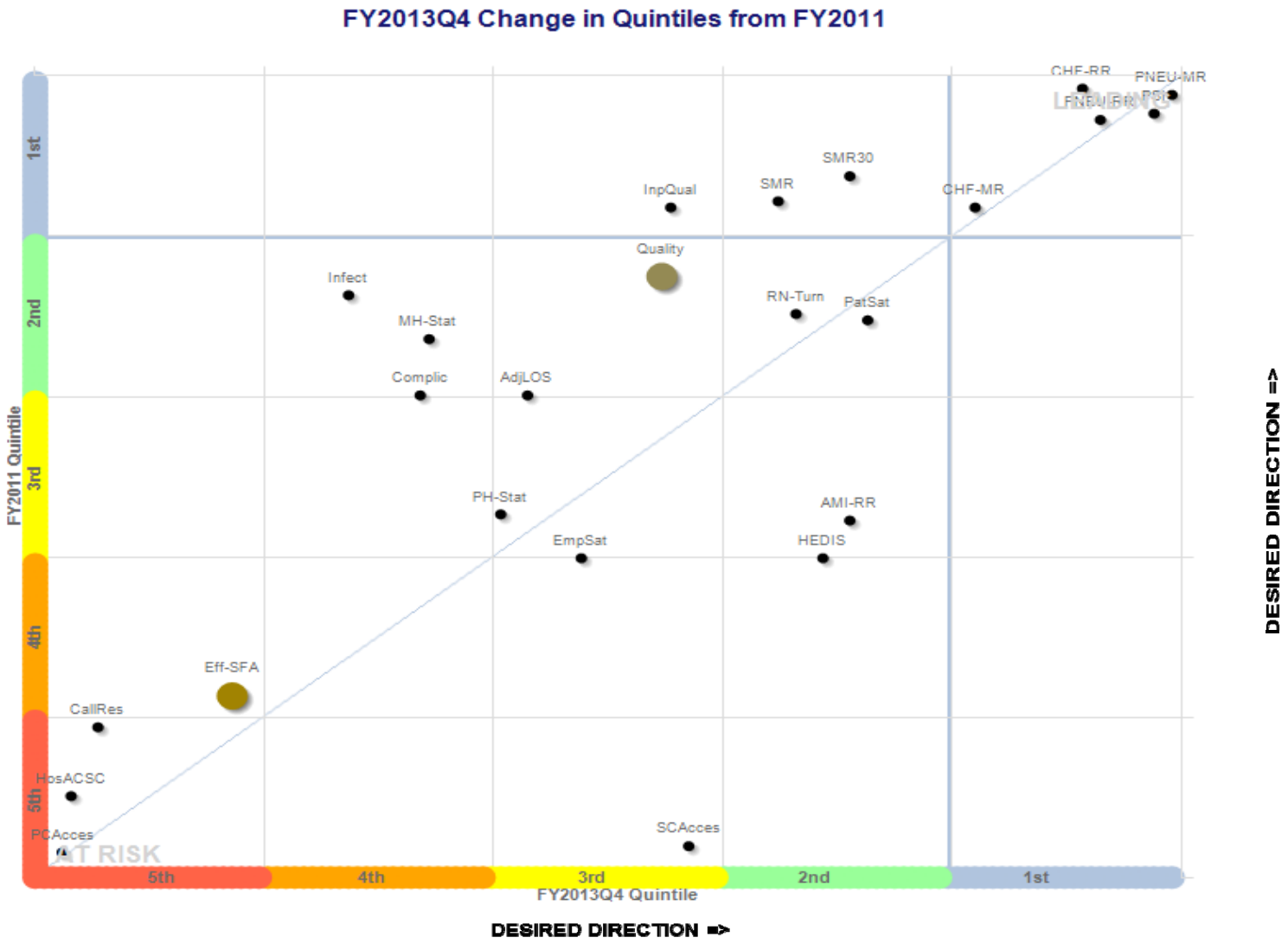
Strategic Analytics for Improvement and Learning (SAIL)[d]



Numbers in parentheses are facility ranking based on z-score of a metric among 128 facilities. Lower number is more favorable.
Marker color: Blue - 1st quintile; Green - 2nd; Yellow - 3rd; Orange - 4th; Red - 5th quintile.

[d] Metric definitions follow the graphs.

Scatter Chart



NOTE

Quintiles are derived from facility ranking on z-score of a metric among 128 facilities. Lower quintile is more favorable.

Metric Definitions

Measure	Definition	Desired direction
ACSC Hospitalization	Ambulatory care sensitive condition hospitalizations (observed to expected ratio)	A lower value is better than a higher value
Adjusted LOS	Acute care risk adjusted length of stay	A lower value is better than a higher value
Call Center Responsiveness	Average speed of call center responded to calls in seconds	A lower value is better than a higher value
Call Responsiveness	Call center speed in picking up calls and telephone abandonment rate	A lower value is better than a higher value
Complications	Acute care risk adjusted complication ratio	A lower value is better than a higher value
Efficiency	Overall efficiency measured as 1 divided by SFA (Stochastic Frontier Analysis)	A higher value is better than a lower value
Employee Satisfaction	Overall satisfaction with job	A higher value is better than a lower value
HC Assoc Infections	Health care associated infections	A lower value is better than a higher value
HEDIS	Outpatient performance measure (HEDIS)	A higher value is better than a lower value
MH Status	MH status (outpatient only, the Veterans RAND 12 Item Health Survey)	A higher value is better than a lower value
MH Wait Time	MH wait time for new and established patients (top 50 clinics)	A higher value is better than a lower value
Oryx	Inpatient performance measure (ORYX)	A higher value is better than a lower value
Physical Health Status	Physical health status (outpatient only, the Veterans RAND 12 item Health Survey)	A higher value is better than a lower value
Primary Care Wait Time	Primary care wait time for new and established patients (top 50 clinics)	A higher value is better than a lower value
PSI	Patient safety indicator	A lower value is better than a higher value
Pt Satisfaction	Overall rating of hospital stay (inpatient only)	A higher value is better than a lower value
RN Turnover	Registered nurse turnover rate	A lower value is better than a higher value
RSMR-AMI	30-day risk standardized mortality rate for acute myocardial infarction	A lower value is better than a higher value
RSMR-CHF	30-day risk standardized mortality rate for congestive heart failure	A lower value is better than a higher value
RSMR-Pneumonia	30-day risk standardized mortality rate for pneumonia	A lower value is better than a higher value
RSRR-AMI	30-day risk standardized readmission rate for acute myocardial infarction	A lower value is better than a higher value
RSRR-CHF	30-day risk standardized readmission rate for congestive heart failure	A lower value is better than a higher value
RSRR-Pneumonia	30-day risk standardized readmission rate for pneumonia	A lower value is better than a higher value
SMR	Acute care in-hospital standardized mortality ratio	A lower value is better than a higher value
SMR30	Acute care 30-day standardized mortality ratio	A lower value is better than a higher value
Specialty Care Wait Time	Specialty care wait time for new and established patients (top 50 clinics)	A higher value is better than a lower value

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: March 11, 2014

From: Director, Northwest Network (10N20)

Subject: **CAP Review of the Portland VA Medical Center, Portland, OR**

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 Portland VA Medical Center, Portland, Oregon.

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

(original signed by:)
Lawrence H. Carroll

Interim Facility Director Comments

Department of Veterans Affairs **Memorandum**

Date: March 6, 2014

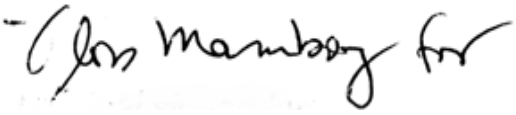
From: Interim Director, Portland VA Medical Center (648/00)

Subject: **CAP Review of the Portland VA Medical Center, Portland, OR**

To: Director, Northwest Network (10N20)

Thank you for the opportunity to review the report on the Office of Inspector General Combined Assessment Program Review at the Portland VA Medical Center during the week of January 27, 2014. We concur with the findings and recommendations and will ensure that actions to correct them are completed as described.

If you have any additional questions or need further information, please contact Nancy Kraft, Chief, Quality and Performance Service at 503-220-5347.



MICHAEL W. FISHER
Interim Medical Center Director

Comments to OIG's Report

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

OIG Recommendations

Recommendation 1. We recommended that the Operative Care Division Quality and Performance Group meet monthly, include the COS as a member, and document its review of National Surgical Office reports.

Concur

Target date for completion: April 2014

Facility response: The Operative Care Division Quality and Performance Group started meeting monthly November, 2013. The COS is a member and has been attending this meeting as of February, 2014. The review of the National Surgical Office reports and any follow-up actions arising from this review are now being documented in meeting minutes and tracked to closure as appropriate.

Recommendation 2. We recommended that processes be strengthened to ensure that all surgical deaths are tracked and reviewed by appropriate clinical staff.

Concur

Target date for completion: May 2014

Facility response: All surgical deaths are now assigned a unique tracking number to facilitate the documentation of reviews and any follow-up actions. Surgical deaths reviewed by the Operative Care Division Quality and Performance Group (Surgical Work Group) will be identified by the assigned tracking numbers in the meeting minutes beginning February 2014.

Recommendation 3. We recommended that all emergency exits on the locked MH unit be alarmed.

Concur

Target date for completion: September 2014

Facility response: Facilities Management will install local and audible alarms on all exit doors on the locked MH unit (5C).

Recommendation 4. We recommended that processes be strengthened to ensure that locked MH unit panic alarm testing includes VA Police response time and that compliance be monitored.

Concur

Target date for completion: June 2014

Facility response: Beginning immediately, Police will include response time in their monthly testing of 5C panic alarms. This will be monitored by the MH EOC team to ensure compliance.

Recommendation 5. We recommended that processes be strengthened to ensure that patient learning assessments are documented within 24 hours of admission and that compliance be monitored.

Concur

Target date for completion: June 2014

Facility response: The "Education Assessment" field in the Nursing Admission Note is now a mandatory field. This documentation will be monitored by the Veterans Health Education & Information Committee to ensure 90% compliance or greater.

Recommendation 6. We recommended that processes be strengthened to ensure that clinicians conducting medication counseling accommodate identified learning barriers and document the accommodations made to address those barriers and that compliance be monitored.

Concur

Target date for completion: June 2014

Facility response: The Pharmacy Discharge Education note template has been updated 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 by pharmacy management to ensure 90% or greater compliance is sustained.

Recommendation 7. We recommended that processes be strengthened to ensure that patients receive ordered aftercare services and/or items within the ordered/expected timeframe.

Concur

Target date for completion: August 2014

Facility response: Portland VA Medical Center Prosthetic representatives, which are new positions, have been created. This staff will have a customer-service focus which includes insuring veterans receive ordered service and/or items. These staff will be in place and trained by May 2014. Additionally, Primary Care staff will be re-educated on follow up process after discharge from acute care to ensure appropriate aftercare services. A random sampling of veterans orders will be monitored until a compliance rate of 90% or greater is accomplished and sustained.

Recommendation 8. We recommended that the facility have a Veterans Health Education Coordinator.

Concur

Target date for completion: January 2014

Facility response: A VHEC was appointed in January 2014.

Recommendation 9. We recommended that nursing managers monitor the staffing methodology that was implemented in June 2013.

Concur

Target date for completion: June 2014

Facility response: Monitoring of the staffing methodology is done by the expert unit-based and facility-based panels annually. The unit-based panels will meet and make recommendations by the end of April each year. The facility-based panel will meet and make recommendations in May of each year. These recommendations will be recorded in the minutes of these meetings.

Recommendation 10. We recommended that all members of the facility and unit-based expert panels receive the required training prior to the next annual staffing plan reassessment.

Concur

Target date for completion: March 2014

Facility response: Required training was completed by all members of the Unit and Facility expert Panels and tracked in TMS. The Chief Nurse Executive is responsible

for assuring these changes are implemented and sustained. The Associate Chief Nursing Officer in Nursing Professional Services is responsible for verifying and tracking completion of TMS training.

Recommendation 11. We recommended that processes be strengthened to ensure that acute care staff document stage for all patients with pressure ulcers and that compliance be monitored.

Concur

Target date for completion: July 2014

Facility response: The skin assessment nursing template is under revision to strengthen pressure ulcer stage documentation. This template, along with staff education on the template, will be implemented April, 2014. A chart review monitor reviewing this documentation will be reported to the Intra-Professional Pressure Ulcer Committee (IPUC) until 90% or greater compliance is accomplished and sustained.

Recommendation 12. We recommended that processes be strengthened to ensure that acute care staff consistently document required pressure ulcer information and that compliance be monitored.

Concur

Target date for completion: July 2014

Facility response: The skin assessment nursing template is under revision to strengthen all pressure ulcer documentation. This template, along with staff education on the template, will be implemented April, 2014. A chart review monitor reviewing this documentation will be reported to the Intra-Professional Pressure Ulcer Committee (IPUC) until 90% or greater compliance is accomplished and sustained.

Recommendation 13. We recommended that processes be strengthened to ensure that all patients discharged with pressure ulcers have wound care follow-up plans and receive dressing supplies prior to being discharged and that compliance be monitored.

Concur

Target date for completion: August 2014

Facility response: The nursing discharge note is under revision to include wound care follow-up plans which will include dressing supplies if needed. The nursing discharge note template will be implemented and nursing staff will be educated on this note by May, 2014. A chart review monitor reviewing this documentation will be reported to the Intra-Professional Pressure Ulcer Committee (IPUC) until 90% or greater compliance is accomplished and sustained.

Recommendation 14. 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: August 2014

Facility response: The nursing discharge note is under revision to include wound care patient/caregiver education provided. The nursing discharge note template will be implemented and nursing staff will be educated on this note by May, 2014. A chart review monitor reviewing this documentation will be reported to the Intra-Professional Pressure Ulcer Committee (IPUC) until 90% or greater compliance is accomplished and sustained.

Recommendation 15. We recommended that the facility establish staff pressure ulcer education requirements and that compliance be monitored.

Concur

Target date for completion: September 2014

Facility response: Pressure ulcer education requirements will be established by a multi-disciplinary workgroup reporting to the Inter-professional Pressure Ulcer Prevention Committee (IPUC). Discipline-specific education materials will be developed as appropriate and relevant staff will be educated on the new pressure ulcer education requirements by September, 2014. The IPUC will monitor pressure ulcer staff education compliance with a goal of 90% or greater completion. Quarterly reports on this information will be presented to the Executive Quality Board.

Recommendation 16. We recommended that processes be strengthened to ensure that staff document resident progress towards restorative nursing goals and that compliance be monitored.

Concur

Target date for completion: August 2014

Facility response: The CLC has created a Restorative Nurse Care Coordinator position that will be staffed and oriented by May, 2014. This nursing position will be responsible for documenting resident progress towards restorative nursing goals. A restorative nursing documentation monitor will be added to the CLC point of care chart reviews. This documentation has a goal of 90% or greater compliance and will be reported to the CLC Quality Action Team for review quarterly.

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Endnotes

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