Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 14-00658-121

Combined Assessment Program Review of the VA Loma Linda Healthcare System Loma Linda, California

April 10, 2014

Washington, DC 20420

To Report Suspected Wrongdoing in VA Programs and Operations
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Glossary

ACA	Affordable Care Act
AVS	after visit summary
CAP	Combined Assessment Program
CLC	community living center
EHR	electronic health record
EOC	environment of care
facility	VA Loma Linda Healthcare System
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 February 3, 2014.

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

- Medication Management

The facility's reported accomplishments were an innovative geriatric medical health model, Joint Commission recognition, Affordable Care Act initiatives, and a patient-centered after visit summary.

Recommendations: We made recommendations in the following six activities:

Quality Management: Include a clinical representative from Medicine Service as a member of the Blood Usage Review Sub-Committee.

Environment of Care: Include environment of care findings from community based outpatient clinic inspections in the facility's Environment of Care Committee minutes. Ensure patient care areas are clean, address and resolve water leaks and structural damage timely, and store clean and dirty items separately. Remove expired medical supplies and medications from patient care areas. Alarm all emergency exits on the locked mental health unit.

Coordination of Care: Provide discharge instructions to patients and/or caregivers, document provision in the electronic health records, and validate patients' and/or caregivers' understanding of the instructions provided. Ensure patients receive ordered aftercare services.

Nurse Staffing: Ensure that the unit-based expert panels include all required members and that all members receive the required training prior to the next annual staffing plan reassessment. Reassess the target nursing hours per patient day for unit 2NE.

Pressure Ulcer Prevention and Management: Perform and document a patient skin inspection and risk scale upon transfer. Accurately document location, stage, risk scale score, and date pressure ulcer acquired for all patients with pressure ulcers. Provide and document pressure ulcer education for patients at risk for and with pressure ulcers and/or their caregivers. Ensure designated employees receive pressure ulcer training.

Community Living Center Resident Independence and Dignity: Complete and document restorative nursing services according to clinician orders and/or residents' care plans.

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 21–29, for the full text of the Directors' comments.) We consider recommendation 6 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 2013 and FY 2014 through February 3, 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 VA Loma Linda Healthcare System, Loma Linda, California,* Report No. 09-02287-215, September 17, 2009).

During this review, we presented crime awareness briefings for 492 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 193 responded. We shared summarized results with facility managers.

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

Reported Accomplishments

Innovative Geriatric Primary Care Medical Health Model

The facility reported to be the only VA medical center to activate the geriatric primary care medical health model. The development and implementation of this interdisciplinary clinic that combines the skills of both geriatrics and psychiatry staff has greatly enhanced the experience of veterans presenting with complex medical issues, including early dementia. Championing the effectiveness of the Patient Aligned Care Team model, the clinic standardized consult management business practices across all clinics, which allowed for a decrease in the more than 18,000 open consults greater than 90 days to 1,400 by the end of FY 2013. The clinic also decreased primary care walk-ins by 30 percent by using secure messaging, automated prescription refills, and a primary care call center.

Joint Commission Recognition

The facility was recognized as a Top Performer on Key Quality Measures® for 2012. This recognition distinguishes the facility for using evidence-based care processes closely linked to positive patient outcomes. The facility was recognized for attaining and sustaining cumulative performance of 95 percent or above across all reported accountability measures for heart attack, heart failure, pneumonia, and surgical care.

ACA Initiatives

In October 2013, VHA's Office of Policy and Planning recognized the facility's ACA[a] initiatives as best practices. In its effort to educate staff and veterans about the ACA, the facility created "behind the badge cards" for each employee, which contain key

[a] The federal health reform legislation known as the ACA was signed into law by the President in 2010.

information regarding the ACA. Additionally, the facility hosted in-person forums for veterans to learn and obtain information about the ACA.

Patient-Centered AVS

The facility's informatics team developed an automated AVS, a clinical summary of outpatient visits, through a grant from the VA Center for Innovation. The AVS is intended to promote patient-centered outpatient care, enhance provider-patient communications, engage patients in their care, and improve recall of medical instructions. Through integration with the EHR system, data is automatically uploaded to the AVS to efficiently create a printout of the clinical data and treatment plan from the office visit. The AVS patient printout includes elements that meet "meaningful use" requirements of the Centers for Medicare and Medicaid Services. In addition, the AVS software provides options for large print and a translator to transform medical jargon into patient-friendly terms. The AVS has been implemented in the primary care clinics at the facility and has been exported to six additional sites. It has been endorsed by the VA Innovation Selection Board to the VA Under Secretary for Health who has approved funding to deploy the AVS nationally.

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 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
	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.	
	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.	• The newly established Blood Usage Review Sub-Committee did not include a clinical representative from Medicine Service as a member.
	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.	

Recommendation

1. We recommended that the Blood Usage Review Sub-Committee include a clinical representative from Medicine Service as a member.

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 selected inpatient units (a medical intensive care, 2NE, 3SE, and 4SW), primary care clinics, the CLC (2 pods), and the emergency and radiology departments. Additionally, we reviewed relevant documents, conversed with key employees and managers, and reviewed 28 employee training records (10 radiology employees, 11 acute MH unit employees, 5 Multidisciplinary Safety Inspection Team members, and 2 occasional acute MH unit employees). The table below shows the areas reviewed for this topic. The areas marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

NM	Areas Reviewed for General EOC	Findings
X	EOC Committee minutes reflected sufficient detail regarding identified deficiencies, corrective actions taken, and tracking of corrective actions to closure.	Six months of EOC Committee minutes reviewed: • Minutes did not consistently reflect EOC findings from community based outpatient clinic inspections.
	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.	• Six of the eight patient care areas were not clean. • There was water leakage and water damage in one shower room and two public restrooms.
X	Infection prevention requirements were met.	• In two of the eight patient care areas, clean and dirty items were not stored separately. • In three of the eight patient care areas, we found expired medical supplies.
X	Medication safety and security requirements were met.	• We found expired medications in five of the eight patient care areas.
	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 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.	
X	Infection prevention requirements in x-ray and fluoroscopy were met.	• Two fluoroscopy rooms were not clean.
NA	Medication safety and security requirements in x-ray and fluoroscopy were met.	
	Sensitive patient information in x-ray and fluoroscopy was protected.	
	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.	
	Areas Reviewed for Acute MH	
	MH EOC inspections were conducted every 6 months.	
	Corrective actions were taken for environmental hazards identified during inspections, and actions were tracked to closure.	

NM	Areas Reviewed for Acute MH (continued)	Findings
	MH unit staff, Multidisciplinary Safety Inspection Team members, and occasional unit workers received training on how to identify and correct environmental hazards, content and proper use of the MH EOC Checklist, and VA's National Center for Patient Safety study of suicide on psychiatric units.	
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.
X	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.	• Floors were in need of cleaning and buffing.

Recommendations

2. We recommended that processes be strengthened to ensure that EOC Committee minutes consistently reflect EOC findings from community based outpatient clinic inspections.

3. We recommended that processes be strengthened to ensure that patient care areas are clean and that water leaks and subsequent structural damage are addressed and resolved timely and that compliance be monitored.

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

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

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

Medication Management

The purpose of this review was to determine whether the appropriate clinical oversight and education were provided to patients discharged with orders for fluoroquinolone oral antibiotics.[3]

We reviewed relevant documents and conversed with key managers and employees. Additionally, we reviewed the EHRs of 35 randomly selected inpatients discharged on 1 of 3 selected oral antibiotics. The table below shows the areas reviewed for this topic. 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 we conversed with key employees. Additionally, we reviewed the EHRs of 33 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.	
X	Clinicians provided discharge instructions to patients and/or caregivers and validated their understanding.	EHRs did not contain evidence that patients' and/or caregivers were provided with discharge instructions for: • Wound care/dressing changes—three of six patients • Prosthetics—5 of 13 patients EHRs did not contain documentation that clinicians validated patients' and/or caregivers understanding of discharge instructions for: • Prosthetics—four of eight patients
X	Patients received the ordered aftercare services and/or items within the ordered/expected timeframe.	• Three of the 19 patients who had services ordered (follow-up appointments) did not receive them.
	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.	

Recommendations

7. We recommended that processes be strengthened to ensure that clinicians provide discharge instructions to patients and/or caregivers and document this in the EHRs and that they validate patients' and/or caregivers' understanding of the discharge instructions they provided and that compliance be monitored.

8. We recommended that processes be strengthened to ensure that patients receive ordered aftercare services.

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 29 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 unit 4SW, CLC unit 1SO, and MH unit 2NE—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.	
	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.	• Units 2NE's and 4SW's unit-based expert panels did not include health technicians or nursing assistants.
X	Members of the expert panels completed the required training.	• Four of the 18 members of the unit-based expert panels had not completed the required training.
X	The actual nursing hours per patient day met or exceeded the target nursing hours per patient day.	• Unit 2NE's average actual nursing hours per patient day were statistically significantly below the target.
	The facility complied with any additional elements required by VHA or local policy.	

Recommendations

9. We recommended that the annual staffing plan reassessment process ensures that unit 2NE's and unit 4SW's unit-based expert panels include all required members and that all members of the unit-based expert panels receive the required training prior to the next annual staffing plan reassessment.

10. We recommended that nurse managers reassess the target nursing hours per patient day for unit 2NE to more accurately plan for staffing and evaluate the actual staffing provided.

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, 26 EHRs of patients with pressure ulcers (10 patients with hospital-acquired pressure ulcers, 10 patients with community-acquired pressure ulcers, and 6 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.	
X	Skin inspections and risk scales were performed upon transfer, change in condition, and discharge.	• Four of the 11 applicable EHRs did not contain documentation that a skin inspection and risk scale were performed upon transfer between units or departments.
X	Staff were generally consistent in documenting location, stage, risk scale score, and date acquired.	• In 6 of the 26 EHRs, staff did not consistently document the location, stage, risk scale score, and/or date acquired.
	Required activities were performed for patients determined to be at risk for 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 8 of the applicable 18 patients at risk for/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.	Facility pressure ulcer staff education requirements reviewed: • Five employee training records did not contain evidence of how to administer the pressure ulcer risk scale, how to conduct a complete skin assessment, and how to 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

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

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

13. 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.

14. We recommended that processes be strengthened to ensure that designated employees receive training on how to administer the pressure ulcer risk scale, how to conduct a complete skin assessment, and how to accurately document findings 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 the EHRs of 10 residents receiving restorative nursing services. We also observed 2 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 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 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 six EHRs, there was no documentation that facility staff completed restorative nursing services according to clinician orders and/or residents' care plans. • In four EHRs, the restorative nursing goals for the identified restorative nursing service(s) ordered by the provider were not documented in the resident care plan.
	Resident progress towards restorative nursing goals was documented, and interventions were modified as needed to promote the resident's accomplishment of goals.	
NA	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.	

NM	Areas Reviewed for Assistive Eating Devices and Dining Service	Findings
	Care planned/ordered assistive eating devices were provided to residents at meal times.	
	Required activities were performed during resident meal periods.	
	The facility complied with any additional elements required by VHA or local policy.	

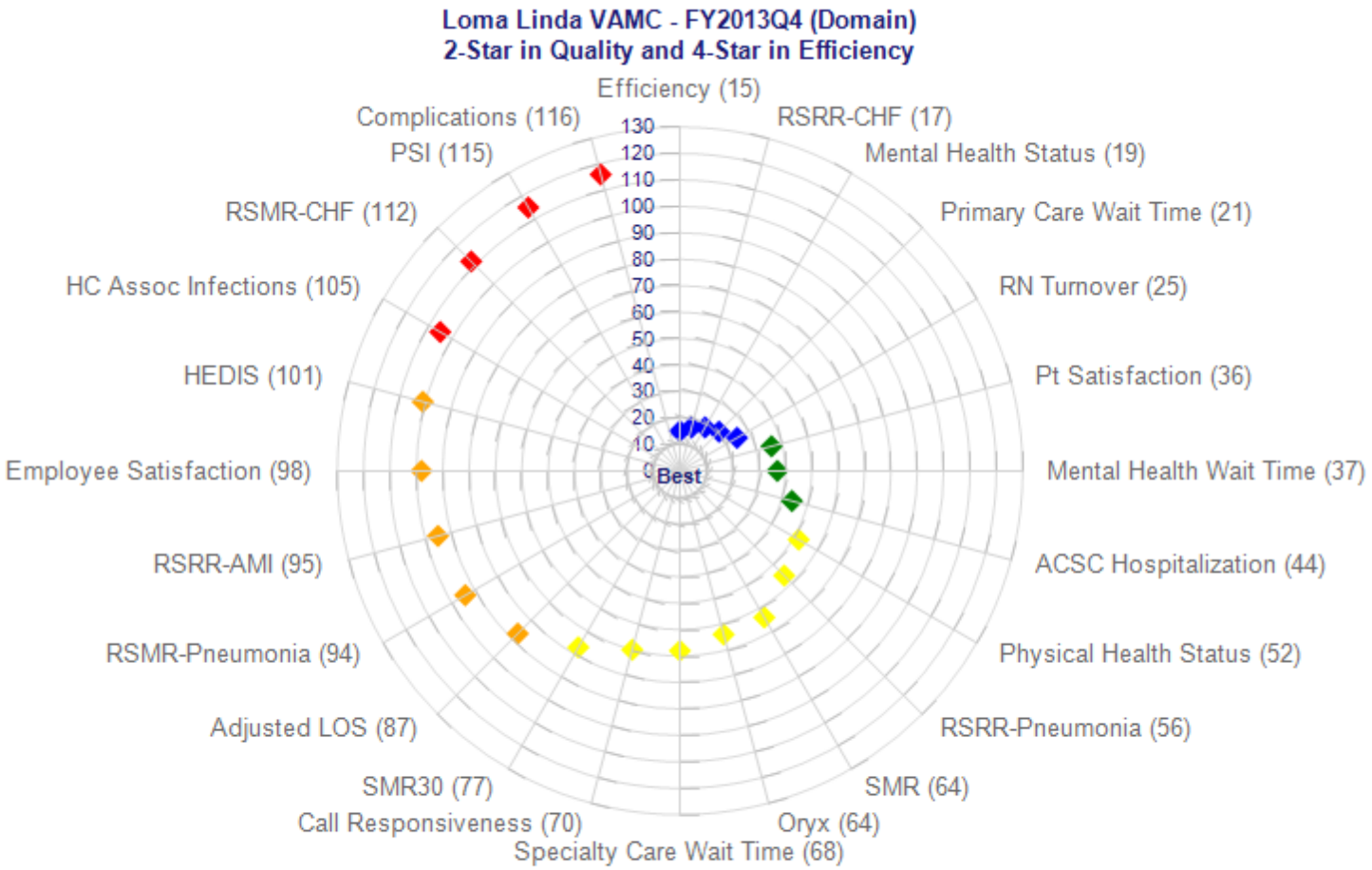
Recommendation

15. 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 and that compliance be monitored.

Facility Profile (Loma Linda/605) FY 2014 through February 2014[b]	
Type of Organization	Tertiary
Complexity Level	1b-High complexity
Affiliated/Non-Affiliated	Affiliated
Total Medical Care Budget in Millions	$479.4
Number of:	
• **Unique Patients**	49,466
• **Outpatient Visits**	252,204
• **Unique Employees**[c]	2,215
Type and Number of Operating Beds (December 2013):	
• **Hospital**	159
• **CLC**	81
• **MH**	26
Average Daily Census (January 2014):	
• **Hospital**	127
• **CLC**	74
• **MH**	20
Number of Community Based Outpatient Clinics	5
Location(s)/Station Number(s)	Victorville/605GA Murrieta/605GB Palm Dessert/605GC Corona/605GD Rancho Cucamonga/605GE
VISN Number	22

[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.

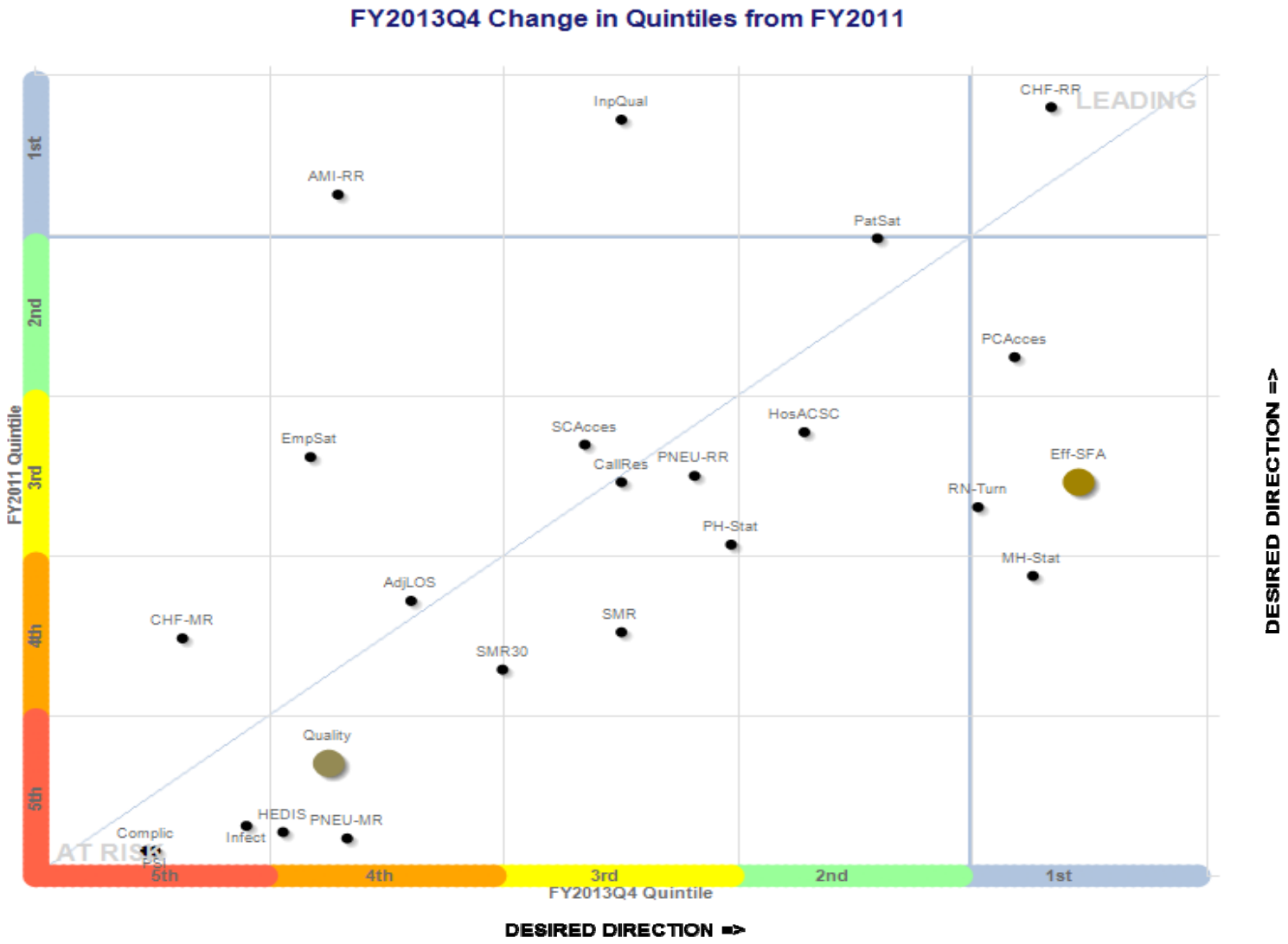
Strategic Analytics for Improvement and Learning (SAIL)[d]



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 25, 2014

From: Director, Desert Pacific Healthcare Network (10N22)

Subject: **CAP Review of the VA Loma Linda Healthcare System, Loma Linda, CA**

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

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

1. I concur with the findings and recommendations in the report of the CAP Review of the VA Loma Linda Healthcare System, Loma Linda, CA.

2. If you have any questions regarding our responses and actions to the recommendations in the report, please contact me at (562) 826-5963.

Stan Johnson

Stan Johnson, MHA, FACHE

Facility Director Comments

Department of Veterans Affairs **Memorandum**

Date: March 24, 2014

From: Director, VA Loma Linda Healthcare System (605/00)

Subject: **CAP Review of the VA Loma Linda Healthcare System, Loma Linda, CA**

To: Director, Desert Pacific Healthcare Network (10N22)

1. I concur with the Loma Linda VA Medical Center's response and action plans as detailed within this report.

Barbara Fallen, FACHE
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 Blood Usage Review Sub-Committee include a clinical representative from Medicine Service as a member.

Concur

Target date for completion: April 30, 2014

Facility response: A Pulmonary Medicine physician has been added to the Committee Charter as a member to the Blood Utilization Review (BUR) Committee. This physician will begin attending as of April 30, 2014.

Recommendation 2. We recommended that processes be strengthened to ensure that EOC Committee minutes consistently reflect EOC findings from community based outpatient clinic inspections.

Concur

Target date for completion: July 30, 2014

Facility response: The Community Based Outpatient Clinic Liaison has been added as an attendee of the EOC Committee. The Liaison will provide quarterly reports including environment of care and CBOC facility safety activities.

In addition, the facility Safety Office will conduct annual safety audits at each CBOC and report the results and corrective actions to the EOC Committee.

Recommendation 3. We recommended that processes be strengthened to ensure patient care areas are clean and that water leaks and subsequent structural damage are addressed and resolved timely and that compliance be monitored.

Concur

Target date for completion: April 30, 2014

Facility response: The facility is in the process of completing the repairs on the congregate shower room located on 3SE.

Environmental Management Service will utilize an aggressive approach toward cleaning all patient care areas on a daily basis. Teams made up of management and staff are being established to complete surveillance of daily and weekly cleaning. A schedule listing areas due to be cleaned is being revised and will be communicated to staff and

leadership upon completion. A summary of the Teams findings will be presented each quarter to the Quality Council.

Recommendation 4. We recommended that processes be strengthened to ensure that clean and dirty items are stored separately and that compliance be monitored.

Concur

Target date for completion: July 15, 2014

Facility response: All issues identified during the week of the OIG CAP survey have been corrected. The facility will strengthen the process of ensuring clean and dirty items are stored separately by delineating a team consisting of Nursing, Infection Control, and Environmental Management Service to identify a list of those items that are acceptable for each type of room/storage. This Team will also set up a process and a schedule for the Team to conduct ongoing monthly surveillance of the clean and dirty utility rooms. Findings will be reported to Quality Council quarterly.

Recommendation 5. We recommended that processes be strengthened to ensure that expired medical supplies and medications are removed from patient care areas and that compliance be monitored.

Concur

Target date for completion: July 31, 2014

Facility response: All issues identified during the week of the OIG CAP survey have been corrected. The facility will strengthen the process of ensuring that expired medical supplies and medications are removed from patient care areas by establishing a team consisting of Nursing, Pharmacy, and Distribution Logistics to identify a list of primary and secondary supply locations and those services that are responsible for ongoing inspection of the locations for outdated/near outdated supplies. Signs will be posted in each area noting the direction in which staff should pull their supplies (for example – stocked from the top, pull from the bottom). All staff accessing the supply locations will be educated on the direction in which supplies need to be pulled. Monitoring will be conducted by the Team monthly and findings will be summarized and reported to Quality Council quarterly.

The medication expiration surveillance program will be strengthened to include documentation of the findings and corrective actions of medication rounds. Findings will be reported to the Quality Council quarterly.

Recommendation 6. We recommended that all emergency exits on the locked MH unit be alarmed.

Concur

Target date for completion: March 10, 2014

Facility response: The facility has completed the installation of alarms on the emergency exits of the locked mental health unit.

Recommendation 7. We recommended that processes be strengthened to ensure that clinicians provide discharge instructions to patients and/or caregivers and document this in the EHRs and that they validate patients' and/or caregivers' understanding of the discharge instructions they provided and that compliance be monitored.

Concur

Target date for completion: July 31, 2014

Facility response: The Facility will strengthen the discharge instruction process by completing the following:

1. Revising the Continuity of Care Policy to include more detailed information regarding the facility's expectation of providing discharge instructions to the patient or their caregiver. The policy will include the requirement for documenting in the EHR that the instructions were given and that the patient/caregiver verbalizes understanding of the information.

2. The EHR Discharge Template will include questions prompting the Nursing Staff to document that the instructions were given and that the patient/caregiver verbalizes understanding of the information.

3. The Initial Nursing Assessment and daily documentation note templates will be revised to contain a "Readiness to Learn" assessment.

Compliance will be monitored through EHR reviews monthly and will be reported to Quality Council monthly for oversight.

Recommendation 8. We recommended that processes be strengthened to ensure that patients receive ordered aftercare services.

Concur

Target date for completion: July 31, 2014

Facility response: The facility will strengthen the process of ensuring that patients receive ordered aftercare services by completing the following:

1. The inpatient Care Managers will document on the Inpatient Care Manager Template a summary of all recommended aftercare services and/or items. The Outpatient Care Manager will receive a "view alert" when the discharge documentation is completed. The Outpatient Care Manager will follow-up on outstanding ordered aftercare services.

2. The Inpatient Care Manager will initiate scheduling for recommended follow-up appointments, when appropriate, prior patient's discharge.

3. The Case Managers will be trained on the new process.

Compliance will be monitored through a review of the EHR on a monthly basis and reported to Quality Council for oversight.

Recommendation 9. We recommended that the annual staffing plan reassessment process ensures that unit 2NE's and unit 4SW's unit-based expert panels include all required members and that all members of the unit-based expert panels receive the required training prior to the next annual staffing plan reassessment.

Concur

Target date for completion: July 31, 2014

Facility response: Staffing Methodology reassessments will be performed on acute care and Community Living Center units. Unit-based expert panel members will be selected using a voluntary application process signed off by the nurse manager and ACNS. The managers will select, at minimum, one person representing each of the nursing roles employed on the unit. The list of panel members and their nursing role will be provided to the Staffing Methodology Coordinator.

Each member of the unit-based panel will complete full TMS training and provide a TMS certificate to the Nurse Manager prior to the first meeting of the panel. Panel members who have previously completed the TMS training will provide their certificates to the Nurse Manager. The Nurse Managers will provide all certificates to the Staffing Methodology Coordinator.

Recommendation 10. We recommended that nurse managers reassess the target nursing hours per patient day for unit 2NE to more accurately plan for staffing and evaluate the actual staffing provided.

Concur

Target date for completion: July 31, 2014

Facility response: As described above, a Staffing Methodology reassessment will be performed on 2NE. Appropriate NHPPD targets will be determined. A calculator tool will be utilized to track the NHPPD being provided on 2NE. The Nurse Manager, Nursing Officer of the Day, and Staffers will use the target NHPPD for 2NE to guide the nurse staffing of the unit.

The Nurse Manager will track the adequacy of 2NE staffing on a daily basis. The Nurse Manager will monitor the occurrence of staffing levels outside the targets on a monthly basis and provide a variance report to their respective ACNS as to why staffing is outside specified methodology.

All managers will present staffing methodology compliance to facility expert panel quarterly.

There has been a recent change in the 2NE leadership, which may have an impact in NHPPD target in the future.

Recommendation 11. We recommended that processes be strengthened to ensure that acute care staff perform and document a patient skin inspection and risk scale upon transfer and that compliance be monitored.

Concur

Target date for completion: September 30, 2014

Facility response: The facility's Pressure Ulcer Prevention and Management policy will be strengthened to include parameters for skin and wound assessment criteria. This criterion will include a skin inspection and risk scale completion upon transfer. The facility will also conduct nursing education on the revised policy content. The facility will conduct a monthly EHR review to determine compliance.

Recommendation 12. We recommended that processes be strengthened to ensure that acute care staff accurately document location, stage, risk scale score, and date pressure ulcer acquired for all patients with pressure ulcers and that compliance be monitored.

Concur

Target date for completion: September 30, 2014

Facility response: The facility will re-educate the acute care RN and LVN nursing staff on accurately documenting the location, stage, risk scale score, and date the pressure ulcer was acquired. Newly hired RN and LVN Nursing employees will continue to participate in the mandatory 8 hour Wound Care Workshop. RN and LVN nursing staff identified to be noncompliant will be referred back for remedial training and may be subject to disciplinary action. The facility will conducted follow-up EHR reviews each month to determine compliance.

Recommendation 13. 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: September 30, 2014

Facility response: The facility will revise the Skin Assessment Template by adding the patient/caregiver learning responses. The EHR will be audited to determine compliance with the documentation of the patient/caregiver learning responses for patients that are at risk for and that have pressure ulcers.

Recommendation 14. We recommended that processes be strengthened to ensure that designated employees receive training on how to administer the pressure ulcer risk scale, how to conduct a complete skin assessment, and how to accurately document findings, and that compliance be monitored.

Concur

Target date for completion: September 30, 2014

Facility response: The facility will strengthen the mandatory training for acute care RN and LVN nursing staff that will include the following:

1. New RN and LVN employees will continue to spend 8 hours with the Wound Care Nurse. All RN and LVN nursing employees will be sent for remedial training should the EHR reviews indication deficiency in documentation.

2. An automated mandatory annual training (TMS) will be developed that will include all requirements for assessment and documentation indicated in the local policy and VHA Directive. A post-test will be included at the end of the annual (TMS) training.

   This TMS training will be in addition to the existing annual competency training and will alternate with the annual competency training every 6 months. A post-test will be developed for the existing annual competency training.

3. The Wound Care Team will conduct additional training for the unit Nurse Managers and Unit Champions so they can assess on a day to day basis the care that is being given and documented for patients that are at high risk and/or have pressure ulcers.

Compliance will be monitored by EHR reviews monthly and reported to Quality Council for oversight.

Recommendation 15. 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 and that compliance be monitored.

Concur

Target date for completion: August 30, 2014

Facility response: The CLC Leadership has developed the following plan to ensure that staff complete and document restorative nursing services according to clinician orders and/or resident's care plans.

Each night, the RN completes a 24 hour chart check to validate that the orders were verified and placed on the Care Plan. To assure that staff is providing care as ordered a weekly peer review audit of restorative nursing care documentation will be performed by the Resident Assessment Coordinator (RAC). Those audited will be the residents scheduled for weekly Care Planning. VA Loma Linda will coordinate with other medical centers within the VISN to participate in completing a peer review on the MDS reviews conducted by the RAC to establish inter-rater reliability.

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Endnotes

[1] References used for this topic included:
- VHA Directive 2009-043, *Quality Management System*, September 11, 2009.
- VHA Handbook 1050.01, *VHA National Patient Safety Improvement Handbook*, March 4, 2011.
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- VHA Handbook 1106.01, *Pathology and Laboratory Medicine Service Procedures*, October 6, 2008.

[2] References used for this topic included:
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- Deputy Under Secretary for Health for Operations and Management, "Guidance on Locking Patient Rooms on Inpatient Mental Health Units Treating Suicidal Patients," October 29, 2010.
- Various requirements of The Joint Commission, the Occupational Safety and Health Administration, the National Fire Protection Association, the Health Insurance Portability and Accountability Act, the American College of Radiology Practice Guidelines and Technical Standards, Underwriters Laboratories.

[3] References used for this topic included:
- VHA Handbook 1108.06, *Inpatient Pharmacy Services*, June 27, 2006.
- VHA Handbook 1108.05, *Outpatient Pharmacy Services*, May 30, 2006.
- VHA Directive 2011-012, *Medication Reconciliation*, March 9, 2011.
- VHA Handbook 1907.01.
- Manufacturer's instructions for Cipro® and Levaquin®.
- Various requirements of The Joint Commission.

[4] References used for this topic included:
- VHA Handbook 1120.04, *Veterans Health Education and Information Core Program Requirements*, July 29, 2009.
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- The Joint Commission, *Comprehensive Accreditation Manual for Hospitals*, July 2013.

[5] The references used for this topic were:
- VHA Directive 2010-034, *Staffing Methodology for VHA Nursing Personnel*, July 19, 2010.
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[6] References used for this topic included:
- VHA Handbook 1180.02, *Prevention of Pressure Ulcers*, July 1, 2011 (corrected copy).
- Various requirements of The Joint Commission.
- Agency for Healthcare Research and Quality Guidelines.
- National Pressure Ulcer Advisory Panel Guidelines.
- The New York State Department of Health, et al., *Gold STAMP Program Pressure Ulcer Resource Guide*, November 2012.

[7] References used for this topic included:
- VHA Handbook 1142.01, *Criteria and Standards for VA Community Living Centers (CLC)*, August 13, 2008.
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