Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 14-00683-130

Combined Assessment Program Review of the Lebanon VA Medical Center Lebanon, Pennsylvania

April 24, 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
EHR	electronic health record
EOC	environment of care
facility	Lebanon VA Medical Center
FPPE	Focused Professional Practice Evaluation
FY	fiscal year
ISIT	interdisciplinary safety inspection team
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

Page

Executive Summary i

Objectives and Scope 1
- Objectives 1
- Scope 1

Reported Accomplishments 2

Results and Recommendations 3
- QM 3
- EOC 6
- Medication Management 9
- Coordination of Care 10
- Nurse Staffing 11
- Pressure Ulcer Prevention and Management 12
- CLC Resident Independence and Dignity 14

Appendixes
- A. Facility Profile 16
- B. Strategic Analytics for Improvement and Learning 17
- C. Interim VISN Director Comments 20
- D. Facility Director Comments 21
- E. OIG Contact and Staff Acknowledgments 27
- F. Report Distribution 28
- G. Endnotes 29

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 24, 2014.

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

- Coordination of Care
- Medication Management

The facility's reported accomplishments were implementing a Centralized Business Office Center that provides a "one stop" shopping concept and serving as the host site for a VA-community mental health (MH) summit.

Recommendations: We made recommendations in the following five activities:

Quality Management: Consistently report results of completed Focused Professional Practice Evaluations for newly hired licensed independent practitioners to the Medical Executive Committee. Ensure Transfusion Committee members from Surgery and Anesthesia Services consistently attend meetings.

Environment of Care: Date multi-dose medication vials after initial use. Ensure that all designated x-ray and fluoroscopy employees receive annual radiation safety training and that all identified MH staff receive training on how to identify and correct environmental hazards, proper use of the MH Environment of Care Checklist, and the VA National Center for Patient Safety study of suicide on psychiatric units. Include VA Police response time in locked MH unit panic alarm testing. Ensure that MH Environment of Care Checklist inspections include participation by all required interdisciplinary safety inspection team members and that the team assigns a risk level per identified deficiency at the time of acute MH unit inspections.

Nurse Staffing: Implement the Veterans Health Administration's staffing methodology.

Pressure Ulcer Prevention and Management: Accurately document location, stage, risk scale score, and date pressure ulcer acquired for all patients with pressure ulcers. Perform and document daily skin inspections and daily risk scales for patients at risk for or with pressure ulcers. Provide and document pressure ulcer education for patients at risk for and with pressure ulcers and/or their caregivers. Ensure all 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.

Community Living Center Resident Independence and Dignity: Ensure staff do not provide medical treatments to residents during meals in the common dining area.

Comments

The Interim Veterans Integrated Service Network Director and 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 will follow up on the planned actions until they are completed.

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

Objectives and Scope

Objectives

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

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

Scope

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

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

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

The review covered facility operations for FY 2013 and FY 2014 through February 24, 2014, and was done in accordance with OIG standard operating procedures for CAP reviews. We also asked the facility to provide the status on the recommendations we made in our previous CAP report (*Combined Assessment Program Review of the Lebanon VA Medical Center, Lebanon, Pennsylvania,* Report No. 11-01605-279, September 14, 2011).

During this review, we presented crime awareness briefings for 95 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 78 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

Centralized Business Office Center

The facility implemented a Centralized Business Office Center that promotes a "one stop" shopping concept. Veterans may go to a central location for enrollment, income testing, identification card processing, beneficiary travel, patient funds, and release of information. Additionally, the Clinical Administrative Service Area is co-located so that veterans may check-in for scheduled appointments or update registration information without having to go to a clinical area.

MH Community Provider Outreach and Partnerships

In September 2013, the facility hosted a MH summit attended by 75 community providers. The goals of the summit were to increase awareness of available VA resources, promote partnership between VA and other local MH care providers, and provide continuing education to MH providers. This effort has fostered further collaboration, including efforts to form an off-site "mini-summit" with community providers.

Results and Recommendations

QM

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

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

NM	Areas Reviewed	Findings
	There was a senior-level committee/group responsible for QM/performance improvement that met regularly. • There was evidence that outlier data was acted upon. • There was evidence that QM, patient safety, and systems redesign were integrated.	
	The protected peer review process met selected requirements: • The PRC was chaired by the Chief of Staff and included membership by applicable service chiefs. • Actions from individual peer reviews were completed and reported to the PRC. • The PRC submitted quarterly summary reports to the MEC. • Unusual findings or patterns were discussed at the MEC.	
X	FPPEs for newly hired licensed independent practitioners were initiated and completed, and results were reported to the MEC.	Eleven profiles reviewed: • Of the nine FPPEs completed, results of eight were not reported to the MEC.
	Specific telemedicine services met selected requirements: • Services were properly approved. • Services were provided and/or received by appropriately privileged staff. • Professional practice evaluation information was available for review.	

NM	Areas Reviewed (continued)	Findings
	Observation bed use met selected requirements: • Local policy included necessary elements. • Data regarding appropriateness of observation bed usage was gathered. • If conversions to acute admissions were consistently 30 percent or more, observation criteria and utilization were reassessed timely.	
	Staff performed continuing stay reviews on at least 75 percent of patients in acute beds.	
	The process to review resuscitation events met selected requirements: • An interdisciplinary committee was responsible for reviewing episodes of care where resuscitation was attempted. • Resuscitation event reviews included screening for clinical issues prior to events that may have contributed to the occurrence of the code. • Data were collected that measured performance in responding to events.	
	The surgical review process met selected requirements: • An interdisciplinary committee with appropriate leadership and clinical membership met monthly to review surgical processes and outcomes. • All surgical deaths were reviewed. • Additional data elements were routinely reviewed.	
	Critical incidents reporting processes were appropriate.	
	The process to review the quality of entries in the EHR met selected requirements: • A committee was responsible to review EHR quality. • Data were collected and analyzed at least quarterly. • Reviews included data from most services and program areas.	
	The policy for scanning non-VA care documents met selected requirements.	

NM	Areas Reviewed (continued)	Findings
X	The process to review blood/transfusions usage met selected requirements: • A committee with appropriate clinical membership met at least quarterly to review blood/transfusions usage. • Additional data elements were routinely reviewed.	Four quarters of Transfusion Committee meeting minutes reviewed: • Clinical representatives from Surgery and Anesthesia Services attended only one of four meetings.
	Overall, if significant issues were identified, actions were taken and evaluated for effectiveness.	
	Overall, senior managers were involved in performance improvement over the past 12 months.	
	Overall, the facility had a comprehensive, effective QM/performance improvement program over the past 12 months.	
	The facility met any additional elements required by VHA or local policy.	

Recommendations

1. We recommended that processes be strengthened to ensure that results of completed FPPEs for newly hired licensed independent practitioners are consistently reported to the MEC.

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

EOC

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

We inspected the acute MH, intensive care, medical/surgical, and hospice units; one CLC; the emergency and radiology departments; the dental and eye clinics; and one primary care clinic. Additionally, we reviewed relevant documents, conversed with key employees and managers, and reviewed 29 employee training records (9 radiology employees, 10 acute MH unit employees, 5 ISIT members, and 5 occasional acute MH unit employees). The table below shows the areas reviewed for this topic. The areas marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

NM	Areas Reviewed for General EOC	Findings
	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.	
X	Medication safety and security requirements were met.	• Two multi-dose medication vials were not dated after initial use.
	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.	
X	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.	• None of the eight x-ray and/or fluoroscopy employees with ≥ 2 years of employment received radiation safety training annually as required by local policy.
	Environmental safety requirements in x-ray and fluoroscopy were met.	
	Infection prevention requirements in x-ray and fluoroscopy were met.	
X	Medication safety and security requirements in x-ray and fluoroscopy were met.	• Two multi-dose medication vials were not dated after initial use.
	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.	
X	MH unit staff, Multidisciplinary Safety Inspection Team members, and occasional unit workers received training on how to identify and correct environmental hazards, content and proper use of the MH EOC Checklist, and VA's National Center for Patient Safety study of suicide on psychiatric units.	• One of the locked MH unit staff, four of the ISIT members, and five of the occasional locked MH unit workers had not completed training on how to identify and correct environmental hazards, proper use of the MH EOC Checklist, and VA's National Center for Patient Safety study of suicide on psychiatric units.
X	The locked MH unit(s) was/were in compliance with MH EOC Checklist safety requirements or an abatement plan was in place.	• Although panic alarm testing was conducted, VA Police response time was not documented.

NM	Areas Reviewed for Acute MH (continued)	Findings
X	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.	VHA MH EOC Checklist requirements reviewed: • MH EOC Checklist inspections did not include participation by all required ISIT members. • ISIT members did not assign a risk level per identified deficiency at the time of acute MH unit inspections.

Recommendations

3. We recommended that processes be strengthened to ensure that multi-dose medication vials are dated after initial use and that compliance be monitored.

4. We recommended that processes be strengthened to ensure that all designated x-ray and fluoroscopy employees receive annual radiation safety training and that compliance be monitored.

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

6. 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.

7. We recommended that processes be strengthened to ensure that MH EOC Checklist inspections include participation by all required ISIT members and that compliance be monitored.

8. We recommended that processes be strengthened to ensure that the ISIT assigns a risk level per identified deficiency at the time of acute MH unit inspections and that compliance be monitored.

Medication Management

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

We reviewed relevant documents and conversed with key managers and employees. Additionally, we reviewed the EHRs of 35 randomly selected inpatients discharged on 1 of 3 selected oral antibiotics. The table below shows the areas reviewed for this topic. 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 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. Any items that did not apply to this facility are marked NA. The facility generally met requirements. We made no recommendations.

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

Nurse Staffing

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

We reviewed facility 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
X	The facility either implemented or reassessed a nurse staffing methodology within the expected timeframes.	• The facility had not implemented VHA's staffing methodology.
	The facility expert panel followed the required processes and included the required members.	
	The unit-based expert panels followed the required processes and included the required members.	
	Members of the expert panels completed the required training.	
NA	The actual nursing hours per patient day met or exceeded the target nursing hours per patient day.	
	The facility complied with any additional elements required by VHA or local policy.	

Recommendation

9. We recommended that nursing managers implement VHA's staffing methodology.

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, 15 EHRs of patients with pressure ulcers (4 patients with hospital-acquired pressure ulcers, 10 patients with community-acquired pressure ulcers, and 1 patient with pressure ulcers at the time of our onsite visit), and 10 employee training records. Additionally, we inspected one patient room. The table below shows the areas reviewed for this topic. The areas marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

NM	Areas Reviewed	Findings
	The facility had a 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 2 of the 15 EHRs, staff did not consistently document the location, stage, risk scale score, and/or date acquired.
X	Required activities were performed for patients determined to be at risk for pressure ulcers and for patients with pressure ulcers.	• Four of the 15 EHRs did not contain consistent documentation that staff performed daily skin inspections and daily risk scales.
	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 12 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: • None of the employee training records contained evidence of how to conduct a complete skin assessment or how to accurately document findings. • Four employee training records did not contain evidence of how to administer the pressure ulcer risk scale.
	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

10. 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.

11. We recommended that processes be strengthened to ensure that acute care staff perform and document daily skin inspections and daily risk scales for patients at risk for or with pressure ulcers and that compliance be monitored.

12. 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.

13. We recommended that processes be strengthened to ensure that all 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 15 EHRs of residents (11 residents receiving restorative nursing services and 4 residents not receiving restorative nursing services but candidates for services). We also observed two meal periods, reviewed one employee training/competency record 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.	
	Resident progress towards restorative nursing goals was documented, and interventions were modified as needed to promote the resident's accomplishment of goals.	
	When restorative nursing services were care planned but were not provided or were discontinued, reasons were documented in the EHR.	
	If residents were discharged from physical therapy, occupational therapy, or kinesiotherapy, there was hand-off communication between Physical Medicine and Rehabilitation Service and the CLC to ensure that restorative nursing services occurred.	
	Training and competency assessment were completed for staff who performed restorative nursing services.	
	The facility complied with any additional elements required by VHA or local policy.	
	Areas Reviewed for Assistive Eating Devices and Dining Service	
	Care planned/ordered assistive eating devices were provided to residents at meal times.	
X	Required activities were performed during resident meal periods.	• Staff provided resident medical treatments during meals in the common resident dining areas.

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.	

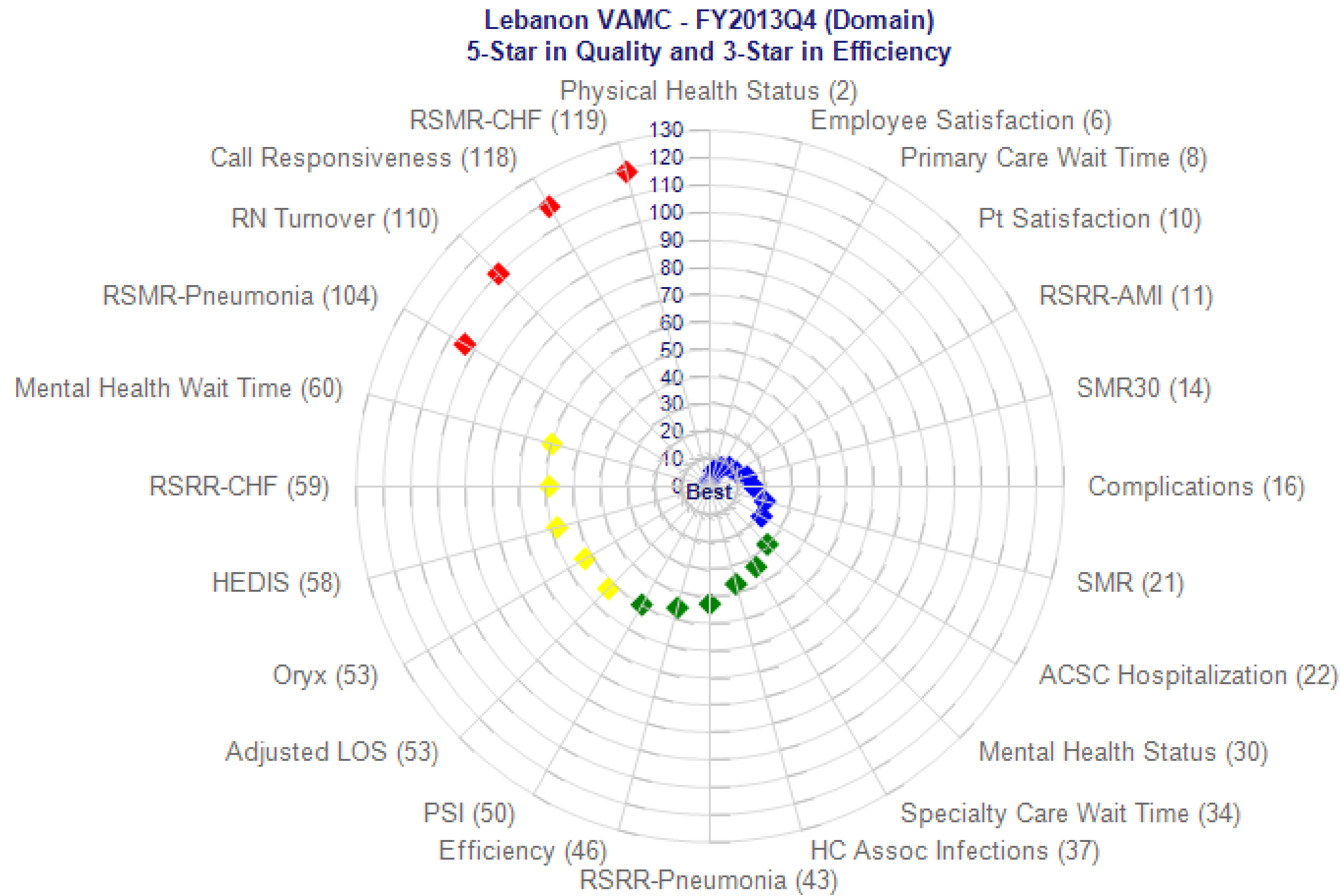
Recommendations

14. We recommended that processes be strengthened to ensure that staff do not provide medical treatments to residents during meals in the common dining area.

Facility Profile (Lebanon/595) FY 2014 through March 2014[a]	
Type of Organization	Tertiary
Complexity Level	2-Medium complexity
Affiliated/Non-Affiliated	Affiliated
Total Medical Care Budget in Millions	$224.7
Number of: • **Unique Patients**	34,932
• **Outpatient Visits**	214,137
• **Unique Employees**[b]	1,059
Type and Number of Operating Beds (January 2014): • **Hospital**	49
• **CLC**	76
• **MH**	43
Average Daily Census (February 2014): • **Hospital**	36
• **CLC**	59
• **MH**	35
Number of Community Based Outpatient Clinics	6
Location(s)/Station Number(s)	Camp Hill/595GA Good Samaritan/5959GB Lancaster/595GC Reading/595GD York Country/595GE Pottsville/Fracksville/595GF
VISN Number	4

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

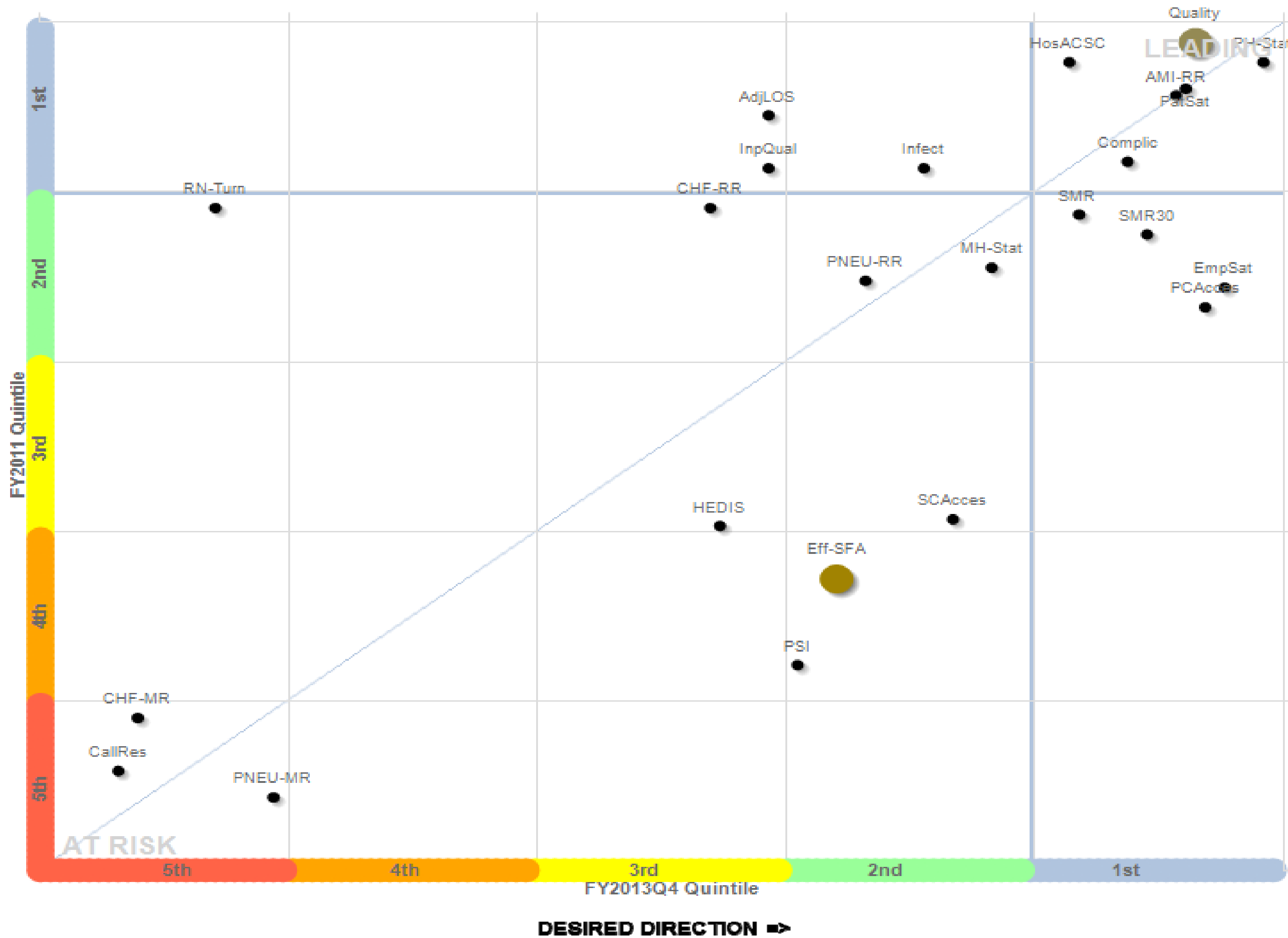
Strategic Analytics for Improvement and Learning (SAIL)[c]



[c] Metric definitions follow the graphs.

Scatter Chart

FY2013Q4 Change in Quintiles from FY2011



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

Interim VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: April 11, 2014

From: Interim Network Director, VA Healthcare – VISN 4 (10N4)

Subject: **CAP Review of the Lebanon VA Medical Center, Lebanon, PA**

To: Director, Baltimore Office of Healthcare Inspections (54BA)

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

1. I have reviewed the response provided by the Lebanon VAMC for the draft report and I am submitting it to your office as requested. I concur with all responses.

2. If you have any questions or require additional information, please contact Barbara Forsha, VISN 4 Quality Management Officer at 412-822-3290.

(original signed by:)
Gary W. Devansky

Attachment

Facility Director Comments

Department of Veterans Affairs **Memorandum**

Date: April 4, 2014

From: Director, Lebanon VA Medical Center (595/00)

Subject: **CAP Review of the Lebanon VA Medical Center, Lebanon, PA**

To: Interim Director, VA Healthcare – VISN 4 (10N4)

1. The recommendations made during the Office of Inspector General (OIG) CAP review the week of February 24, 2014, have been reviewed. Resolution actions have been accomplished on 6 of the recommendations. A plan of action has been developed, implemented and will be thoroughly monitored to ensure satisfactory completion on the remaining findings.

2. I would like to personally thank the OIG CAP Survey Team members for their professionalism and consultative assistance throughout this review. Your review provides an opportunity to further strengthen our processes and the great care provided to our Veterans.

3. If you have any questions or require additional information, please contact the Laine Hellein, Director, Quality Management, at 717-272-6621, ext. 4407.

(original signed by:)
Robert W. Callahan, Jr.

Comments to OIG's Report

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

OIG Recommendations

Recommendation 1. We recommended that processes be strengthened to ensure that results of completed FPPEs for newly hired licensed independent practitioners are consistently reported to the MEC.

Concur

Target date for completion: 8/1/2014

Facility response: As of 3/19/2014 the FPPE completions are documented in a graph format with details of each review recommended for completion are reflected in the Medical Staff Executive Board meeting minutes. The Credentialing and Privileging committee also began documenting completed FPPE's in their minutes with provider specific information beginning in March.

Recommendation 2. We recommended that processes be strengthened to ensure that Transfusion Committee members from Surgery and Anesthesia Services consistently attend meetings.

Concur

Target date for completion: 8/1/2014

Facility response: All committee members were notified of meeting attendance expectations. Committee chair will be monitoring attendance and accountable actions will be taken when attendance trends are identified.

Recommendation 3. We recommended that processes be strengthened to ensure that multi-dose medication vials are dated after initial use and that compliance be monitored.

Concur

Target date for completion: 8/1/2014

Facility response: A Performance Improvement Group is reviewing the multi-dose vial labeling policy to ensure compliance with initial use and manufactures guidelines. Additionally, the Performance Improvement Group will ensure the 28 day expiration dates are in compliance with refrigeration requirements. Pharmacy is currently dispensing multi-dose vials to non-refrigerated settings with 28 day expiration dates in place.

Recommendation 4. We recommended that processes be strengthened to ensure that all designated x-ray and fluoroscopy employees receive annual radiation safety training and that compliance be monitored.

Concur

Target date for completion: 7/1/2014

Facility response: Annual radiation safety training has been added to the mandatory annual training on TMS for all Radiology employees. The radiology manager will be monitoring for ongoing compliance all x-ray and fluoroscopy staff.

Recommendation 5. We recommended that processes be strengthened to ensure that all locked MH unit staff, ISIT members, and occasional locked MH unit workers receive training on how to identify and correct environmental hazards, proper use of the MH EOC Checklist, and VA's National Center for Patient Safety study of suicide on psychiatric units and that compliance be monitored.

Concur

Target date for completion: 7/1/2014

Facility response: Lebanon VA Medical Center staff were assigned the MHEOCC TMS training of which 76% of Lebanon Medical Center staff have completed. Clinical staff and the ISIT team members that provide care on the locked MH unit were assigned both clinical and non-clinical MHEOCC training in TMS. The ISIT members have completed 100% of required training and 84% of the clinical staff have completed required training. Quarterly reports will be presented to Medical Staff Executive Board for compliance with training requirements.

Recommendation 6. 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: 7/1/2014

Facility response: The MH unit panic alarm was tested on 3/20/2014 which included VA Police response times. This test will be completed monthly and be monitored by the Behavioral Health Associate Chief Nursing Service.

Recommendation 7. We recommended that processes be strengthened to ensure that MH EOC Checklist inspections include participation by all required ISIT members and that compliance be monitored.

Concur

Target date for completion: 7/1/2014

Facility response: The ISIT was made a formalized sub-committee of the Environment of Care Committee. ISIT team members met on 3/27/2014 and completed the MH EOC checklist. Future quarterly inspection results are presented to the Environment of Care Committee.

Recommendation 8. We recommended that processes be strengthened to ensure that the ISIT assigns a risk level per identified deficiency at the time of acute MH unit inspections and that compliance be monitored.

Concur

Target date for completion: 7/1/2014

Facility response: The Patient Safety Manager and the Patient Safety Officer completed a risk assessment for all safety concerns noted from the MH EOC conducted on 3/27/2014. All safety concerns with a risk score of 4 will be monitored by unit staff during unit safety rounds until abatement is completed. Reports and monitoring will be completed at the ISIT sub-committee with report to the Environment of Care Committee.

Recommendation 9. We recommended that nursing managers implement VHA's staffing methodology.

Concur

Target date for completion: 9/1/2014

Facility response: Annual staffing methodology was completed per VHA Directive 2010-034. Staffing methodology will be presented and reviewed at the April session of the Executive Committee of the Governing Board.

Recommendation 10. 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: 9/1/2014

Facility response: All acute care nursing staff have been assigned to complete the MyVeHU Campus training for hospital acquired pressure ulcers. Nurse Managers will review 10 charts per month to monitor compliance with results reported to the Patient Care Services Executive Board.

Recommendation 11. We recommended that processes be strengthened to ensure that acute care staff perform and document daily skin inspections and daily risk scales for patients at risk for or with pressure ulcers and that compliance be monitored.

Concur

Target date for completion: 9/1/2014

Facility response: All acute care nursing staff have been assigned to complete the MyVeHU Campus training for hospital acquired pressure ulcers. Nurse Managers will review 10 charts per month to monitor compliance with results reported to the Patient Care Services Executive Board.

Recommendation 12. 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: 9/1/2014

Facility response: All acute care nursing staff have been assigned to complete the MyVeHU Campus training for hospital acquired pressure ulcers. Nurse Managers will review 10 charts per month to monitor compliance with results reported to the Patient Care Services Executive Board.

Recommendation 13. We recommended that processes be strengthened to ensure that all 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: 9/1/2014

Facility response: All acute care nursing staff have been assigned to complete the MyVeHU Campus training for hospital acquired pressure ulcers. Nurse Managers will review 10 charts per month to monitor compliance with results reported to the Patient Care Services Executive Board.

Recommendation 14. We recommended that processes be strengthened to ensure that staff do not provide medical treatments to residents during meals in the common dining area.

Concur

Target date for completion: 8/1/2014

Facility response: Privacy and dignity training will be completed by all nursing staff. Nurse Managers will review each dining space during 10 different meal times per month and any identified medical treatment issues will be reviewed and addressed monthly by the Patient Care Services Executive Board.

OIG Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the OIG at (202) 461-4720.
Onsite Contributors	Sonia Whig, MS, LDN, Team Leader Gail Bozzelli, RN Donald Braman, RN, BSN Margie Chapin, RT (R, MR, CT), JD Jennifer Christensen, DPM Katharine Foster, RN Terri Julian, PhD Melanie Oppat, MEd, LDN Gerard Poto, Special Agent, Office of Investigations
Other Contributors	Elizabeth Bullock Shirley Carlile, BA Paula Chapman, CTRS Lin Clegg, PhD Marnette Dhooghe, MS Matt Frazier, MPH Cynthia Gallegos Jeff Joppie, BS Victor Rhee, MHS Carol Torczon, RN Julie Watrous, RN, MS Jarvis Yu, MS

Report Distribution

VA Distribution

Office of the Secretary
VHA
Assistant Secretaries
General Counsel
Interim Director, VA Healthcare – VISN 4 (10N4)
Director, Lebanon VA Medical Center (595/00)

Non-VA Distribution

House Committee on Veterans' Affairs
House Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
House Committee on Oversight and Government Reform
Senate Committee on Veterans' Affairs
Senate Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
Senate Committee on Homeland Security and Governmental Affairs
National Veterans Service Organizations
Government Accountability Office
Office of Management and Budget
U.S. Senate: Robert P. Casey, Jr.; Patrick J. Toomey
U.S. House of Representatives: Charles W. Dent, Jim Gerlach, Scott Perry, Joseph R. Pitts

This report is available at www.va.gov/oig.

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.
- VHA Directive 2010-017, *Prevention of Retained Surgical Items*, April 12, 2010.
- VHA Directive 2010-025, *Peer Review for Quality Management*, June 3, 2010.
- VHA Directive 2010-011, *Standards for Emergency Departments, Urgent Care Clinics, and Facility Observation Beds*, March 4, 2010.
- VHA Directive 2009-064, *Recording Observation Patients*, November 30, 2009.
- VHA Handbook 1100.19, *Credentialing and Privileging*, October 15, 2012.
- VHA Directive 2008-063, *Oversight and Monitoring of Cardiopulmonary Resuscitative Events and Facility Cardiopulmonary Resuscitation Committees,* October 17, 2008.
- VHA Handbook 1907.01, *Health Information Management and Health Records*, September 19, 2012.
- VHA Directive 6300, *Records Management*, July 10, 2012.
- VHA Directive 2009-005, *Transfusion Utilization Committee and Program*, February 9, 2009.
- VHA Handbook 1106.01, *Pathology and Laboratory Medicine Service Procedures*, October 6, 2008.

[2] References used for this topic included:
- VHA Directive 1105.01, *Management of Radioactive Materials*, October 7, 2009.
- VHA Directive 2011-007, *Required Hand Hygiene Practices*, February 16, 2011.
- VHA Handbook 1105.04, *Fluoroscopy Safety*, July 6, 2012.
- VHA Handbook 1160.01, *Uniform Mental Health Services in VA Medical Centers and Clinics*, September 11, 2008.
- VA Radiology, "Online Guide," http://vaww1.va.gov/RADIOLOGY/OnLine_Guide.asp, updated October 4, 2011.
- VA National Center for Patient Safety, "Privacy Curtains and Privacy Curtain Support Structures (e.g., Track and Track Supports) in Locked Mental Health Units," Patient Safety Alert 07-04, February 16, 2007.
- VA National Center for Patient Safety, "Multi-Dose Pen Injectors," Patient Safety Alert 13-04, January 17, 2013.
- VA National Center for Patient Safety, *Mental Health Environment of Care Checklist (MHEOCC)*, April 11, 2013.
- Deputy Under Secretary for Health for Operations and Management, "Mitigation of Items Identified on the Environment of Care Checklist," November 21, 2008.
- Deputy Under Secretary for Health for Operations and Management, "Change in Frequency of Review Using the Mental Health Environment of Care Checklist," April 14, 2010.
- 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.
- VHA Handbook 1907.01.
- 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.
- VHA "Staffing Methodology for Nursing Personnel," August 30, 2011.

[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.
- VHA Handbook 1142.03, *Requirements for Use of the Resident Assessment Instrument (RAI) Minimum Data Set (MDS)*, January 4, 2013.
- Centers for Medicare and Medicaid Services, *Long-Term Care Facility Resident Assessment Instrument User's Manual*, Version 3.0, May 2013.
- VHA Manual M-2, Part VIII, Chapter 1, *Physical Medicine and Rehabilitation Service*, October 7, 1992.
- Various requirements of The Joint Commission.