
**Department of Veterans Affairs**
**Office of Inspector General**

**Office of Healthcare Inspections**

**Report No. 14-00684-132**

# Combined Assessment Program Review of the VA Northern Indiana Health Care System Fort Wayne, Indiana

**April 28, 2014**

**Washington, DC 20420**

**To Report Suspected Wrongdoing in VA Programs and Operations**
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# Glossary

| | |
|---|---|
| CAP | Combined Assessment Program |
| CLC | community living center |
| EHR | electronic health record |
| EOC | environment of care |
| facility | VA Northern Indiana Health Care 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 March 3, 2014.

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

- Medication Management
- Coordination of Care
- Nurse Staffing

**Recommendations:** We made recommendations in the following four activities:

*Quality Management*: Consistently complete actions from peer reviews, and report them to the Peer Review Committee. Require the Medical Executive Committee to discuss and document its approval of the use of another facility's physicians for teledermatology services. Obtain teledermatology physicians' professional practice evaluation information from the providing facility. Consistently perform continuing stay reviews on at least 75 percent of patients in acute beds. Ensure that the Acute Care Committee reviews each code episode and that code reviews consistently include screening for clinical issues prior to the code that may have contributed to the occurrence of the code. Keep the recipient list current for the automated e-mail notification for the patient incident reporting process. Review the quality of entries in the electronic health record at least quarterly. Require the quality control policy for scanning to include how a scanned image is annotated to identify that it has been scanned. Ensure that a member from Anesthesia Service attends Transfusion Utilization Committee meetings and that the blood/transfusions usage review process includes the results of proficiency testing and the results of peer reviews when transfusions did not meet criteria.

*Environment of Care:* Comply with Veterans Health Administration and local smoke free policies. Ensure the Veterans Integrated Service Network 11 Director establishes a non-facility team to conduct a comprehensive environment of care evaluation of the facility. Establish a policy for equipment inspection and testing. Post signs in waiting and procedure rooms within radiology asking female patients to notify staff if they may be pregnant. Ensure that expired medications are removed from radiology crash carts and that clinical staff are trained on how to locate the crash cart expiration date. Require that all occasional locked mental health unit workers receive training on identifying and correcting environmental hazards, content and proper use of the Mental Health Environment of Care Checklist, and VA's National Center for Patient Safety study of suicide on psychiatric units.

*Pressure Ulcer Prevention and Management:* Establish an interprofessional pressure ulcer committee. Perform and document a patient skin inspection and risk scale at discharge. Accurately document location, stage, risk scale score, and date pressure ulcer acquired for all patients with pressure ulcers. Perform and document 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. Establish staff pressure ulcer education requirements.

*Community Living Center Resident Independence and Dignity:* Provide all care planned/ordered assistive eating devices to residents for use during meals.

## 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 21–31, 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
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# Objectives and Scope

## Objectives

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

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

## Scope

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

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

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

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

The review covered facility operations for FY 2012, FY 2013, and FY 2014 through March 7, 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 Northern Indiana Health Care System, Marion, Indiana,* Report No. 11-00026-146, April 19, 2011). We made a repeat recommendation in QM.

During this review, we presented crime awareness briefings for 48 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 112 responded. We shared summarized results with facility managers.

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

# Results and Recommendations

## QM

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

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

| NM | Areas Reviewed | Findings |
|---|---|---|
| | There was a senior-level committee/group responsible for QM/performance improvement that met regularly.<br>• There was evidence that outlier data was acted upon.<br>• There was evidence that QM, patient safety, and systems redesign were integrated. | |
| X | The protected peer review process met selected requirements:<br>• The PRC was chaired by the Chief of Staff and included membership by applicable service chiefs.<br>• Actions from individual peer reviews were completed and reported to the PRC.<br>• The PRC submitted quarterly summary reports to the MEC.<br>• Unusual findings or patterns were discussed at the MEC. | Twelve months of PRC meeting minutes reviewed:<br>• Of the 56 actions expected to be completed, 39 (70 percent) were not reported to the PRC. |
| | Focused Professional Practice Evaluations for newly hired licensed independent practitioners were initiated and completed, and results were reported to the MEC. | |
| X | Specific telemedicine services met selected requirements:<br>• Services were properly approved.<br>• Services were provided and/or received by appropriately privileged staff.<br>• Professional practice evaluation information was available for review. | Twelve months of MEC meeting minutes reviewed:<br>• There was no evidence that the MEC had approved the use of telemedicine technology for teledermatology services.<br>• Neither of the providing facility's physicians' professional practice evaluation information was available for review. |

| NM | Areas Reviewed (continued) | Findings |
|---|---|---|
| | Observation bed use met selected requirements:<br>• Local policy included necessary elements.<br>• Data regarding appropriateness of observation bed usage was gathered.<br>• If conversions to acute admissions were consistently 30 percent or more, observation criteria and utilization were reassessed timely. | |
| X | Staff performed continuing stay reviews on at least 75 percent of patients in acute beds. | Twelve months of continuing stay data reviewed:<br>• For 2 months, less than 75 percent of acute inpatients were reviewed. |
| X | The process to review resuscitation events met selected requirements:<br>• An interdisciplinary committee was responsible for reviewing episodes of care where resuscitation was attempted.<br>• Resuscitation event reviews included screening for clinical issues prior to events that may have contributed to the occurrence of the code.<br>• Data were collected that measured performance in responding to events. | Twelve months of Acute Care Committee meeting minutes reviewed:<br>• There was no evidence that the committee reviewed each code episode.<br>• There was inconsistent documentation that code reviews included screening for clinical issues prior to code that may have contributed to the occurrence of the code. |
| | The surgical review process met selected requirements:<br>• An interdisciplinary committee with appropriate leadership and clinical membership met monthly to review surgical processes and outcomes.<br>• All surgical deaths were reviewed.<br>• Additional data elements were routinely reviewed. | |
| X | Critical incidents reporting processes were appropriate. | • The recipient list for the automatic e-mail notification was not current. |
| X | The process to review the quality of entries in the EHR met selected requirements:<br>• A committee was responsible to review EHR quality.<br>• Data were collected and analyzed at least quarterly.<br>• Reviews included data from most services and program areas. | • There was no evidence that the quality of entries in the EHR was reviewed. This was a repeat finding from the previous CAP review. |
| X | The policy for scanning non-VA care documents met selected requirements. | • The scanning policy did not include how a scanned image is annotated to identify that it has been scanned. |

| NM | Areas Reviewed (continued) | Findings |
|---|---|---|
| X | The process to review blood/transfusions usage met selected requirements:<br>• A committee with appropriate clinical membership met at least quarterly to review blood/transfusions usage.<br>• Additional data elements were routinely reviewed. | Four months of Transfusion Utilization Committee meeting minutes reviewed:<br>• A clinical representative from Anesthesia Service did not attend any meetings.<br>• The review process did not consistently include the results of proficiency testing and the results of peer reviews when transfusions did not meet criteria. |
| | 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 actions from peer reviews are consistently completed and reported to the PRC.

**2.** We recommended that the MEC discuss and document its approval of the use of another facility's physicians for teledermatology services.

**3.** We recommended that the facility obtain teledermatology physicians' professional practice evaluation information from the providing facility.

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

**5.** We recommended that processes be strengthened to ensure that the Acute Care Committee reviews each code episode and that code reviews consistently include screening for clinical issues prior to the code that may have contributed to the occurrence of the code.

**6.** We recommended that the recipient list for the automated e-mail notification for the patient incident reporting process is kept current.

**7.** We recommended that processes be strengthened to ensure that the quality of entries in the EHR is reviewed at least quarterly.

**8.** We recommended that the quality control policy for scanning include how a scanned image is annotated to identify that it has been scanned.

**9.** We recommended that processes be strengthened to ensure that a member from Anesthesia Service attends Transfusion Utilization Committee meetings and that the blood/transfusions usage review process consistently includes the results of proficiency testing and the results of peer reviews when transfusions did not meet criteria.

## 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 specialty and primary care clinics, the medical/surgical unit, the CLCs, urgent care, x-ray, fluoroscopy, and the acute MH unit. In response to comments in the Employee Assessment Review survey, we also inspected administrative areas, hallways, stairwells, elevators, and the exterior grounds. Additionally, we reviewed relevant documents, conversed with key employees and managers, and reviewed 30 employee training records (10 radiology employees, 10 acute MH unit employees, 5 Multidisciplinary Safety Inspection Team members, and 5 occasional acute MH unit employees). The table below shows the areas reviewed for this topic. The 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. | |
| X | Fire safety requirements were met. | VHA and local smoking policies reviewed. At the Fort Wayne division:<br>• We observed and found evidence of smoking within 35 feet of entrances and outside designated smoking areas.<br>• There was no smoking shelter for patients and staff. |
| X | Environmental safety requirements were met. | • We found general building maintenance issues at both divisions that included:<br>▪ Chipped, cracked, and peeling paint<br>▪ Scratched and gouged doors<br>▪ Broken floor tiles<br>▪ Broken wall mounted dispensers in women's restrooms<br>▪ Broken signs<br>▪ Unrepaired walls after sign removal<br>• We found general cleanliness issues at both divisions that included:<br>▪ Dirty vents<br>▪ Dirty door kick plates<br>▪ Dirty stairwells |

| NM | Areas Reviewed for General EOC (continued) | Findings |
|---|---|---|
| | Infection prevention requirements were met. | |
| | Medication safety and security requirements were met. | |
| | Auditory privacy requirements were met. | |
| | The facility complied with any additional elements required by VHA, local policy, or other regulatory standards. | |
| | **Areas Reviewed for Radiology** | |
| | The facility had a Radiation Safety Committee, the committee met at least every 6 months and established a quorum for meetings, and the Radiation Safety Officer attended meetings. | |
| | Radiation Safety Committee meeting minutes reflected discussion of any problematic areas, corrective actions taken, and tracking of corrective actions to closure. | |
| X | Facility policy addressed frequencies of equipment inspection, testing, and maintenance. | • The facility did not have a policy addressing the frequency of equipment inspection and testing. |
| | The facility had a policy for the safe use of fluoroscopic equipment. | |
| | The facility Director appointed a Radiation Safety Officer to direct the radiation safety program. | |
| | X-ray and fluoroscopy equipment items were tested by a qualified medical physicist before placed in service and annually thereafter, and quality control was conducted on fluoroscopy equipment in accordance with facility policy/procedure. | |
| | Designated employees received initial radiation safety training and training thereafter with the frequency required by local policy, and radiation exposure monitoring was completed for employees within the past year. | |
| X | Environmental safety requirements in x-ray and fluoroscopy were met. | • Signs were not posted in waiting and procedure rooms asking female patients to notify staff if they may be pregnant. |
| | Infection prevention requirements in x-ray and fluoroscopy were met. | |
| X | Medication safety and security requirements in x-ray and fluoroscopy were met. | • We found expired medications in one of two crash carts, and clinical staff did not know how to locate the crash cart expiration date. |
| | Sensitive patient information in x-ray and fluoroscopy was protected. | |

| NM | Areas Reviewed for Radiology (continued) | Findings |
|---|---|---|
| | 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. | • Three of the occasional locked MH unit workers had not completed training on identifying and correcting 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. |
| | The locked MH unit(s) was/were in compliance with MH EOC Checklist safety requirements or an abatement plan was in place. | |
| | The facility complied with any additional elements required by VHA, local policy, or other regulatory standards. | |

## Recommendations

**10.** We recommended that the facility comply with VHA and local smoking policies and that compliance be monitored.

**11.** We recommended that the VISN 11 Director establish a non-facility team to conduct a comprehensive EOC evaluation of the facility and ensure that deficiencies are corrected and that an action plan is developed to ensure the facility is properly cleaned and maintained.

**12.** We recommended that the facility establish a policy for equipment inspection and testing and that compliance with the newly established policy be monitored.

**13.** We recommended that signs be posted in waiting and procedure rooms within radiology asking female patients to notify staff if they may be pregnant.

**14.** We recommended that processes be strengthened to ensure that expired medications are removed from radiology crash carts and clinical staff are trained on how to locate the crash cart expiration date and that compliance be monitored.

**15.** We recommended that processes be strengthened to ensure that all occasional locked MH unit workers receive training on identifying and correcting 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 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 28 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 five 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 and unit-based expert panel documents and 27 training files, and we conversed with key employees. Additionally, we reviewed the actual nursing hours per patient day for three randomly selected units—acute medical/surgical unit 4E, CLC-1B, and MH unit 2N—for 50 randomly selected days between October 1, 2012, and September 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 |
|---|---|---|
| | 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. | |
| | The unit-based expert panels followed the required processes and included the required members. | |
| | Members of the expert panels completed the required training. | |
| | The actual nursing hours per patient day met or exceeded the target nursing hours per patient day. | |
| | The facility complied with any additional elements required by VHA or local policy. | |

## 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, 10 EHRs of patients with pressure ulcers (2 patients with hospital-acquired pressure ulcers and 8 patients with community-acquired pressure ulcers), and 10 employee training records. The table below shows the areas reviewed for this topic. The areas marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

| NM | Areas Reviewed | Findings |
|---|---|---|
| | The facility had a pressure ulcer prevention policy, and it addressed prevention for all inpatient areas and for outpatient care. | |
| X | The facility had an interprofessional pressure ulcer committee, and the membership included a certified wound care specialist. | • The facility did not have an interprofessional pressure ulcer committee. |
| | 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. | • Two of the 10 EHRs did not contain documentation that a skin inspection and risk scale were performed at discharge. |
| X | Staff were generally consistent in documenting location, stage, risk scale score, and date acquired. | • In 6 of the 10 EHRs, staff did not consistently document the location, stage, risk scale score, 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 10 EHRs did not contain consistent documentation that staff performed 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. | |
| 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:<br>• None of the EHRs for the applicable eight patients at risk for/with a pressure ulcer contained evidence that education was provided. |

| NM | Areas Reviewed (continued) | Findings |
|---|---|---|
| X | The facility defined requirements for staff pressure ulcer education, and acute care staff received training on how to administer the pressure ulcer risk scale, conduct the complete skin assessment, and accurately document findings. | • The facility had not developed staff pressure ulcer education requirements. |
| NA | The facility complied with selected fire and environmental safety, infection prevention, and medication safety and security requirements in pressure ulcer patient rooms. | |
| NA | The facility complied with any additional elements required by VHA or local policy. | |

## Recommendations

**16.** We recommended that the facility establish an interprofessional pressure ulcer committee.

**17.** We recommended that processes be strengthened to ensure that acute care staff perform and document a patient skin inspection and risk scale at discharge and that compliance be monitored.

**18.** 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.

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

**20.** 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.

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

## CLC Resident Independence and Dignity

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

We reviewed 10 EHRs of residents receiving restorative nursing services. We also observed 13 residents during 2 meal periods, reviewed 10 employee training/competency records and other relevant documents, and conversed with key employees. The table below shows the areas reviewed for this topic. The area marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

| NM | Areas Reviewed | Findings |
|---|---|---|
| | The facility offered restorative nursing services. | |
| | Facility staff completed and documented restorative nursing services, including active and passive range of motion, bed mobility, transfer, and walking activities, according to clinician orders and residents' care plans. | |
| | 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** | |
| X | Care planned/ordered assistive eating devices were provided to residents at meal times. | • Twelve of the 32 (38 percent) assistive eating devices care planned/ordered were not provided to residents. |
| | Required activities were performed during resident meal periods. | |

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

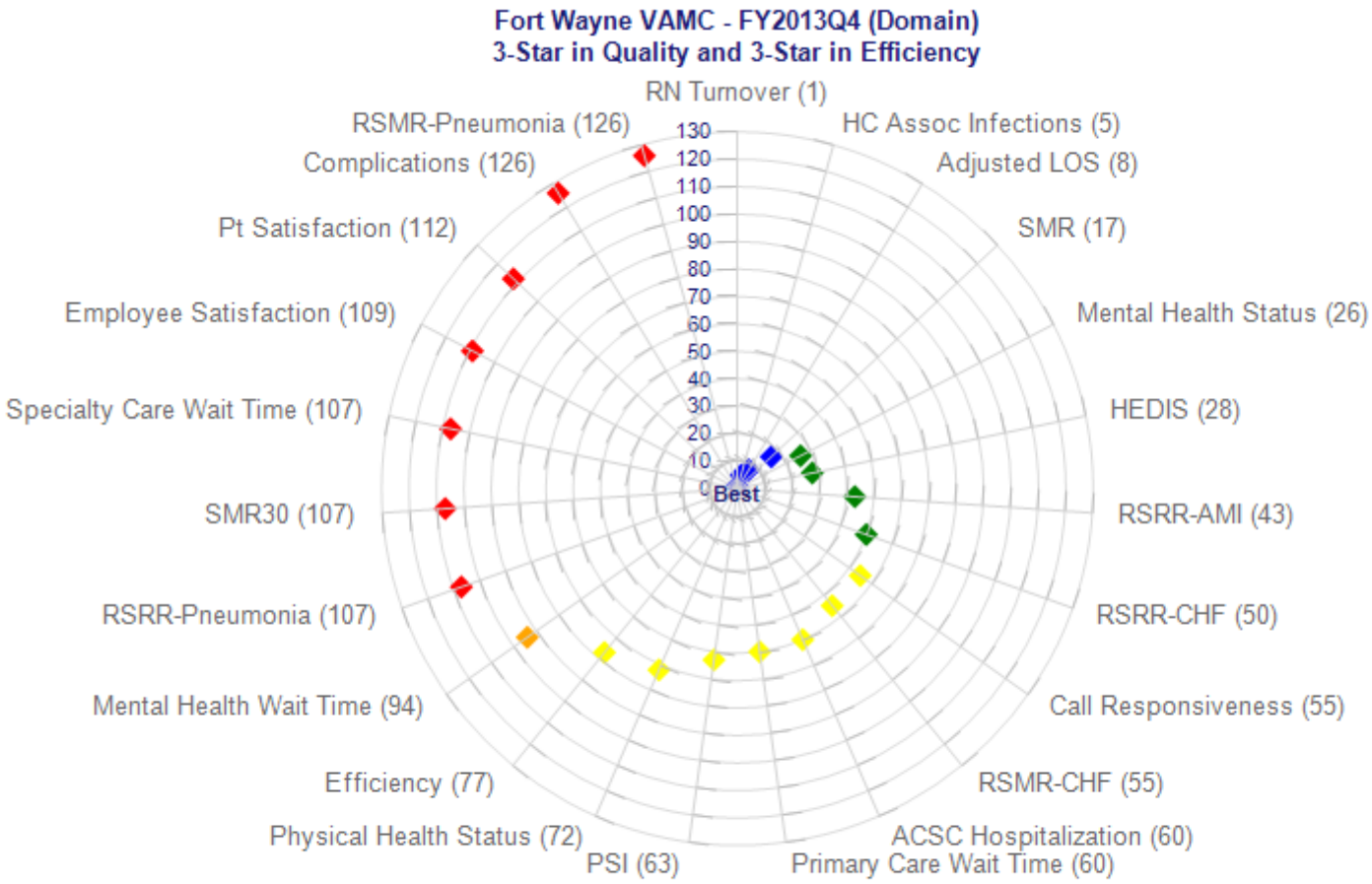
## Recommendations

**22.** We recommended that processes be strengthened to ensure that all care planned/ordered assistive eating devices are provided to residents for use during meals.

| Facility Profile (Fort Wayne/610) 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** | $236.9 |
| **Number of:** | |
| • **Unique Patients** | 34,682 |
| • **Outpatient Visits** | 212,240 |
| • **Unique Employees**[b] | 1,564 |
| **Type and Number of Operating Beds (January 2014):** | |
| • **Hospital** | 197 |
| • **CLC** | 180 |
| • **MH** | 30 |
| **Average Daily Census (February 2014):** | |
| • **Hospital** | 60 |
| • **CLC** | 97 |
| • **MH** | 22 |
| **Number of Community Based Outpatient Clinics** | 4 |
| **Location(s)/Station Number(s)** | South Bend/610GA<br>Muncie/610GB<br>Goshen/610GC<br>Peru/610GD |
| **VISN Number** | 11 |

[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.

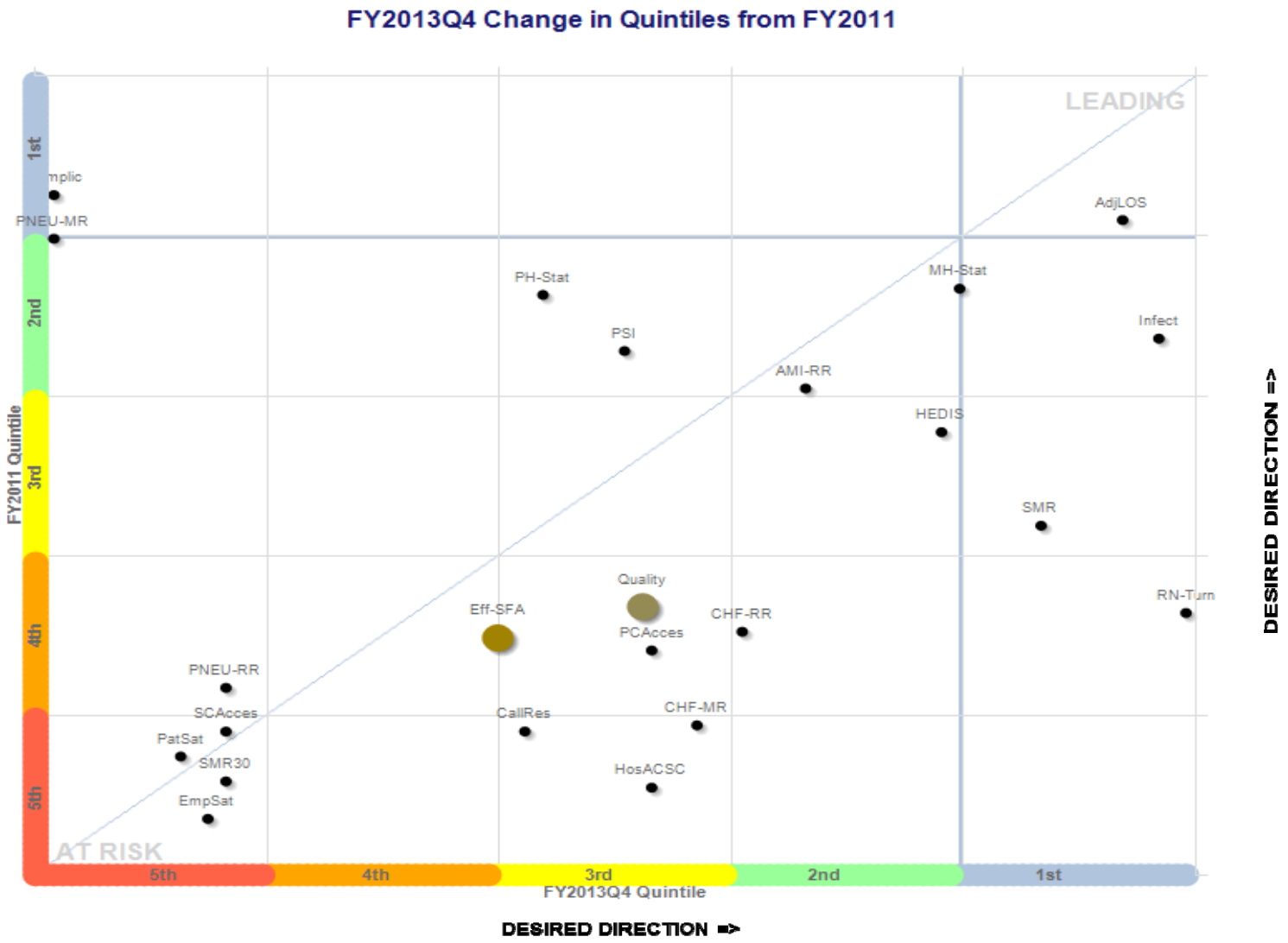
# Strategic Analytics for Improvement and Learning (SAIL)[c]




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

[c] Metric definitions follow the graphs.

# Scatter Chart




**NOTE**

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

# Metric Definitions

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

# VISN Director Comments

**Department of Veterans Affairs** **Memorandum**

**Date:** April 11, 2014

**From:** Director, Veterans in Partnership (10N11)

**Subject:** **CAP Review of the VA Northern Indiana Health Care System, Fort Wayne, IN**

**To:** Director, Kansas City Office of Healthcare Inspections (54KC)

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

1. I concur with the findings and recommendations in the report of the Combined Assessment Program review of the VA Northern Indiana Health Care System.

2. If you have any questions regarding our responses and actions to the recommendations in the report, please contact me.

Thank You

*(original signed by:)*
Paul Bockelman, FACHE
Network Director, VISN 11

# Comments to OIG's Report

The following Director's comments are submitted in response to recommendation 11 in the OIG report:

**OIG Recommendation**

**Recommendation 11.** We recommended that the VISN 11 Director establish a non-facility team to conduct a comprehensive EOC evaluation of the facility and ensure that deficiencies are corrected and that an action plan is developed to ensure the facility is properly cleaned and maintained.

Concur

Target date for completion: May 15, 2014

Facility response: A VISN environment of care Site Visit has been scheduled to be conducted from May 13 through May 15, 2014, at VA Northern Indiana Health Care System.

# Facility Director Comments

**Department of Veterans Affairs** **Memorandum**

**Date:** April 11, 2014

**From:** Director, VA Northern Indiana Health Care System (610/00)

**Subject:** **CAP Review of the VA Northern Indiana Health Care System, Fort Wayne, IN**

**To:** Director, Veterans in Partnership (10N11)

1. I concur with the VA Northern Indiana Health Care System's response and action plans as detailed within this report.

Thank you

Denise M. Deitzen, 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 processes be strengthened to ensure that actions from peer reviews are consistently completed and reported to the PRC.

Concur

Target date for completion: April 9, 2014

Facility response: The Peer Review Committee will monitor actions on a monthly basis. All delays will be trended and analyzed on a quarterly basis and improvement actions will be reported to Clinical Executive Board (CEB) during the scheduled quarterly reports.

**Recommendation 2.** We recommended that the MEC discuss and document its approval of the use of another facility's physicians for teledermatology services.

Concur

Target date for completion: May 30, 2014

Facility response: Telehealth Coordinator coordinates signatures of approval on Memorandums of Understanding. The Memorandum of Understanding will be reviewed and approved by the Medical Executive Committee prior to Director approval. Professional Standards Board members will review the Service Agreement for details of the bidirectional reporting and frequency of reporting between the Receiving Facility and the Providing Facility.

**Recommendation 3.** We recommended that the facility obtain teledermatology physicians' professional practice evaluation information from the providing facility.

Concur

Target date for completion: April 30, 2014

Facility response: The teledermatology providers' professional practice evaluations will be requested by VA Northern Indiana Health Care System and will be reviewed by the Professional Standards Board.

**Recommendation 4.** We recommended that processes be strengthened to ensure that continuing stay reviews are consistently performed on at least 75 percent of patients in acute beds.

Concur

Target date for completion: July 1, 2014

Facility response: Utilization reviews for continued stays will be performed on at least 75 percent of patients in acute beds according to the National Utilization Management performance measure. Utilization Management nurses will complete weekly audits to ensure compliance remain at or above 75 percent. Once compliance is sustained at greater than 75 percent for three consecutive months, the audits will be completed monthly. The data will be reported to the Utilization Management Committee on a monthly basis and quarterly to the Clinical Executive Board.

**Recommendation 5.** We recommended that processes be strengthened to ensure that the Acute Care Committee reviews each code episode and that code reviews consistently include screening for clinical issues prior to the code that may have contributed to the occurrence of the code.

Concur

Target date for completion: May 14, 2014

Facility response: The Acute Care Committee evaluated all codes for the calendar year of 2013 to ensure that the review of clinical issues prior to each code was assessed. This was completed during two special sessions on March 11 and March 18, 2014. The compilation report did not identify any significant findings. The committee will assess each code episode for potential clinical issues that may have occurred prior to the code and capture this assessment in the committee meeting minutes.

**Recommendation 6.** We recommended that the recipient list for the automated e-mail notification for the patient incident reporting process is kept current.

Concur

Target date for completion: March 27, 2014 and ongoing

Facility response: The recipient list for the email notification for the Critical Incident Tracking Notification (CITN) was updated on March 3, 2014. A test notification will be performed semi-annually to assure the list remains up to date and will be discussed in the VA Northern Indiana Health Care System Surgery Staff Meeting.

**Recommendation 7.** We recommended that processes be strengthened to ensure that the quality of entries in the EHR is reviewed at least quarterly.

Concur

Target date for completion: March 10, 2014

Facility response: The Medical Records Committee met on March 10, 2014, and developed an action plan to rectify citations. The committee recently assigned a new chair and the plan is to meet at a minimum on a quarterly basis. The service lines have been notified of the medical record review schedule and expectations. Each service/program will submit aggregate data, recommendations, and action plans if necessary to the committee. The Medical Records Committee will report discrepancies quarterly to the Clinical Executive Board.

**Recommendation 8.** We recommended that the quality control policy for scanning include how a scanned image is annotated to identify that it has been scanned.

Concur

Target date for completion: June 1, 2014

Facility response: The scanning policy has been revised to include how scanned images are annotated as being scanned. The draft scanning policy is currently going through the routing process for final approval.

**Recommendation 9.** We recommended that processes be strengthened to ensure that a member from Anesthesia Service attends Transfusion Utilization Committee meetings and that the blood/transfusions usage review process consistently includes the results of proficiency testing and the results of peer reviews when transfusions did not meet criteria.

Concur

Target date for completion: June 1, 2014

Facility response: A designated member from Anesthesia Service has been identified and will be attending the Transfusion Utilization Committee. This will be tracked by the attendance roster from the committee meetings. The committee will review the results of proficiency testing and results of peer reviews when transfusions do not meet criteria at each meeting.

**Recommendation 10.** We recommended that the facility comply with VHA and local smoking policies and that compliance be monitored.

Concur

Target date for completion: August 1, 2014

Facility response: VA Northern Indiana Health Care System police will provide a verbal or written warning for first time violators who are found to be smoking within 35 feet of entrances and outside designated smoking areas. Repeated violators will result in the issuance of Federal Violation Notice (FVN) and a fine. Environmental Safety will identify locations for ash receptacles and ensure receptacles are in place by April 30, 2014. Environmental Safety will monitor to ensure that the ash receptacles remain in the designated areas and report to the Environment of Care Board on a quarterly basis. A plan has been initiated to determine proper location and structure for a smoking shelter. This plan will also be monitored through completion on a monthly basis through the Environment of Care Board.

**Recommendation 12.** We recommended that the facility establish a policy for equipment inspection and testing and that compliance with the newly established policy be monitored.

Concur

Target date for completion: May 1, 2014

Facility response: A Standard Operating Procedure (SOP) was drafted on April 10, 2014, to ensure that equipment inspection and testing was completed. This will be monitored by the Radiology Supervisor and reported quarterly to the Environment of Care Board.

**Recommendation 13.** We recommended that signs be posted in waiting and procedure rooms within radiology asking female patients to notify staff if they may be pregnant.

Concur

Target date for completion: June 1, 2014

Facility response: The Radiology Supervisors evaluated the waiting and procedure exam rooms and were able to determine where signs were needed. Work orders were submitted. Temporary signs were placed in the appropriate areas and will be replaced once the permanent signs arrive.

**Recommendation 14.** We recommended that processes be strengthened to ensure that expired medications are removed from radiology crash carts and clinical staff are trained on how to locate the crash cart expiration date and that compliance be monitored.

Concur

Target date for completion: July 31, 2014

Facility response: The Pharmacy Procedure 119-35 “Ward Inspections” was revised on March 12, 2014. 73/73 pharmacy employees have received the training to the revised

procedure. Results of monthly monitoring will be aggregated and reported quarterly to the Acute Care Committee by the pharmacy chief or designee.

**Recommendation 15.** We recommended that processes be strengthened to ensure that all occasional locked MH unit workers receive training on identifying and correcting 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 and that compliance be monitored.

Concur

Target date for completion: June 30, 2014

Facility response: Additional training assignments were made on April 10, 2014, in the Training Management System (TMS) to ensure the occasional Mental Health Unit workers are properly trained on how to identify and correct environmental hazards, the proper use of the Mental Health Environment of Care Checklist, and the VA's National Center for Patient Safety study of suicide on Mental Health units. The additional assignments in TMS were made to the following groups: Environmental Management Service, Engineering, all Patient Care Support staff not previously assigned including Registered Nurses, Licensed Practical Nurses, Nursing Assistants, and Student Nurse Technicians; Medical Clerks, Chaplains, Recreational Clinic staff, Safety Department staff, and Suicide Prevention Coordinators. The module has been assigned to an additional 294 staff members. The assignment was expanded to include all Patient Care staff members; previously the assignment was limited to Mental Health staff only. The Nurse Managers will track compliance for those assigned to work as relief or occasional workers in a Mental Health care area. Monthly compliance reports will be run through TMS by the Education Department and will be reported to the facility Environment of Care Board.

**Recommendation 16.** We recommended that the facility establish an interprofessional pressure ulcer committee.

Concur

Target date for completion: April 30, 2014

Facility response: The Interprofessional Wound Care Committee has been established and started meeting in January 2014. The committee meets on a quarterly basis.

**Recommendation 17.** We recommended that processes be strengthened to ensure that acute care staff perform and document a patient skin inspection and risk scale at discharge and that compliance be monitored.

Concur

Target date for completion: July 31, 2014

Facility response: Training has been provided to acute care nursing staff on January 8–9, 2013, January 22–26, 2013, and February 9–28, 2014, regarding skin assessments and risk scales to ensure that the documentation tools are utilized to capture skin inspection and risk scales at discharge. 100 percent of staff will complete training. New staff will receive training as part of their unit orientation. Acute care nursing staff will monitor five discharge charts per month for documentation of a patient skin inspection and risk scale at discharge. The monitor findings will be reported to the Interprofessional Wound Care Committee. The reviews will continue until 3 concurrent months are sustained at 100% of appropriate documentation.

**Recommendation 18.** 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: July 31, 2014

Facility response: Training has been provided to acute care nursing staff on January 8–9, 2013, January 22–26, 2013 and February 9–28, 2014 regarding the documentation of skin assessments, including location, stage, risk scale score, and date pressure ulcer was acquired. 100 percent of staff will complete training. New staff will receive training as part of their unit orientation. Acute care nursing staff will monitor up to five charts concurrently per month to validate that staff have accurately documented location, stage, risk scale score, and date pressure ulcer acquired. The monitor findings will be reported to the Interprofessional Wound Care Committee. The reviews will continue until 3 concurrent months are sustained at 100% for appropriate documentation.

**Recommendation 19.** We recommended that processes be strengthened to ensure that acute care staff perform and document daily risk scales for patients at risk for or with pressure ulcers and that compliance be monitored.

Concur

Target date for completion: July 31, 2014

Facility response: Training regarding skin assessments and risk scales has been provided to acute care RN staff on January 8–9, 2013, January 22–26, 2013 and February 9–28, 2014. 100 percent of staff will complete training. Compliance will be monitored by using VA Nursing Outcomes Database (VANOD) Skin Risk Report data to capture the appropriate documentation of daily risk scales for patients at risk for or with pressure ulcers. This data will be sent to the Interprofessional Wound Care Committee on a monthly basis by the Nurse Manager/designee. The reviews will continue until 3 concurrent months are sustained at 100% of appropriate documentation.

**Recommendation 20.** 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: July 31, 2014

Facility response: A new template was created to document pressure ulcer education. 100 percent of acute care RN staff completed training with the new template in March 2014. The Nurse Manager/designee will review up to five charts per month of Veterans at risk for and with pressure ulcers to ensure pressure ulcer education is documented to patients and/or caregivers. This data will be reported to the Interprofessional Wound Care Committee monthly. The reviews will continue until 3 concurrent months are sustained at 100 percent for appropriate documentation.

**Recommendation 21.** We recommended that the facility establish staff pressure ulcer education requirements and that compliance be monitored.

Concur

Target date for completion: April 16, 2014 for initial training and ongoing for new staff

Facility response: RN staff on units caring for Veterans at risk for pressure ulcers (Community Living Center and Acute Medicine Unit) will receive Level 1 Wound Care Training. Level 1 training is to be completed by April 16, 2014, for 100 percent of designated staff. New staff will participate in one of the scheduled monthly online Level 1 training sessions within 30 days of hire. This training will be added to the RN New Employee Training Plan for these units. The training will be monitored by the unit managers on a monthly basis, and will be reported to the Nursing Executive Advisory Board on a quarterly basis.

**Recommendation 22.** We recommended that processes be strengthened to ensure that all care planned/ordered assistive eating devices are provided to residents for use during meals.

Concur

Target date for completion: April 30, 2014

Facility response: The Nurse Managers and the Registered Dietician reviewed appropriateness of all currently ordered assistive devices on March 4, 2014. Care Plans were adjusted to ensure that the appropriate devices were identified. The assistive devices have been labelled with the appropriate Veteran's name to assist staff in providing to the Veterans during meal times. The Clinical Manager will observe meals on each unit five times per month on the Community Living Center (CLC) units to verify appropriate assistive devices are available during mealtimes and corrections are sustained. Monthly monitoring will begin May 1, 2014, and will continue for at least

3 months to ensure compliance is above 90 percent. This will be reported to the CLC Continuous Readiness Committee.

# OIG Contact and Staff Acknowledgments

| | |
|---|---|
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# Endnotes

[1] References used for this topic included:
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- 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 2008-052, *Smoke-Free Policy for VA Health Care Facilities*, August 26, 2008.
- 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.
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- 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.
- U.S. Pharmacopeia <797>, *Guidebook to Pharmaceutical Compounding–Sterile Preparations*, June 1, 2008.
- 10 CFR 20, Subpart F.
- 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.
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