Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 14-00685-156

Combined Assessment Program Review of the VA Montana Health Care System Fort Harrison, Montana

May 19, 2014

Washington, DC 20420

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

Glossary

CAP	Combined Assessment Program
CLC	community living center
COS	Chief of Staff
EHR	electronic health record
EOC	environment of care
facility	VA Montana Health Care System
FY	fiscal year
IHS	Indian Health Service
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 two activities:

- Environment of Care
- Nurse Staffing

The facility's reported accomplishment was a partnership with Indian Health Service to create a climate of collaboration to support Native American veteran needs.

Recommendations: We made recommendations in the following five activities:

Quality Management: Require the Medical Executive Committee to document its discussion of unusual findings or patterns from Peer Review Committee quarterly summary reports. Ensure that the Cardiopulmonary Resuscitation Committee reviews each code episode and that code reviews include screening for clinical issues prior to the code that may have contributed to the occurrence of the code. Require that there is a Surgical Work Group that meets monthly, includes the Chief of Staff as a member, and documents its review of National Surgical Office reports. Ensure all surgical deaths are tracked and reviewed by appropriate clinical staff. Review the quality of entries in the electronic health record at least quarterly.

Medication Management: Conduct and document patient learning assessments.

Coordination of Care: Provide discharge instructions on all aftercare needs to patients and/or caregivers, and document this in the electronic health record. Validate patients' and/or caregivers' understanding of the discharge instructions provided. Ensure patients receive ordered aftercare services and/or items within the ordered/expected timeframe.

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

Community Living Center Resident Independence and Dignity: Document resident progress towards restorative nursing goals. Ensure employees who perform restorative nursing services receive training on and competency assessment for range of motion and resident transfers.

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 20–27, 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

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 6, 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 Montana Health Care System, Fort Harrison, Montana,* Report No. 09-03744-233, August 26, 2010).

During this review, we presented crime awareness briefings for 110 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 209 responded. We shared summarized results with the facility Director.

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

Reported Accomplishment

IHS Partnership

The facility has successfully developed a partnership with IHS leadership to create a climate of collaboration to support Native American veteran needs. Based on a national agreement between VHA and IHS, local implementation plans were developed with each IHS facility to authorize VA to reimburse the facility for services they provide to eligible veterans who are American Indian/Alaska Native. Each local implementation plan describes the responsibilities of the VA facility and the IHS facility and includes a list of health care services available through each facility. This list of services is unique to the IHS facility and used as the basis for reimbursement. The facility has established local implementation plans with all IHS facilities within Montana. American Indian/Alaska Native veterans benefit from this partnership by being able to get care closer to home.

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.	
X	The protected peer review process met selected requirements: • The PRC was chaired by the COS and included membership by applicable service chiefs. • Actions from individual peer reviews were completed and reported to the PRC. • The PRC submitted quarterly summary reports to the MEC. • Unusual findings or patterns were discussed at the MEC.	Twelve months of MEC meeting minutes reviewed: • Unusual findings and/or patterns from the quarterly summary reports were not documented as discussed.
	Focused Professional Practice Evaluations for newly hired licensed independent practitioners were initiated and completed, and results were reported to the MEC.	
NA	Specific telemedicine services met selected requirements: • Services were properly approved. • Services were provided and/or received by appropriately privileged staff. • Professional practice evaluation information was available for review.	

NM	Areas Reviewed (continued)	Findings
	Observation bed use met selected requirements: • Local policy included necessary elements. • Data regarding appropriateness of observation bed usage was gathered. • If conversions to acute admissions were consistently 30 percent or more, observation criteria and utilization were reassessed timely.	
	Staff performed continuing stay reviews on at least 75 percent of patients in acute beds.	
X	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.	Twelve months of Cardiopulmonary Resuscitation Committee meeting minutes reviewed: • There was no evidence that the committee reviewed each episode. • There was no evidence that code reviews included screening for clinical issues prior to the code that may have contributed to the occurrence of the code.
X	The surgical review process met selected requirements: • An interdisciplinary committee with appropriate leadership and clinical membership met monthly to review surgical processes and outcomes. • All surgical deaths were reviewed. • Additional data elements were routinely reviewed.	• The facility did not have an interdisciplinary committee that included appropriate leadership and clinical membership, met monthly, and reviewed surgical processes and outcomes. • The facility's process did not ensure that all surgical deaths were tracked and reviewed by appropriate clinical staff.
	Critical incidents reporting processes were appropriate.	
X	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.	Twelve months of Medical Records Review Committee meeting minutes reviewed: • EHR quality data was not analyzed quarterly.
	The policy for scanning non-VA care documents met selected requirements.	

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

Recommendations

1. We recommended that the MEC document its discussion of unusual findings or patterns from PRC quarterly summary reports.

2. We recommended that processes be strengthened to ensure that the Cardiopulmonary Resuscitation Committee reviews each code episode and that code reviews include screening for clinical issues prior to the code that may have contributed to the occurrence of the code.

3. We recommended that the facility have a Surgical Work Group that meets monthly, includes the COS as a member, and documents its review of National Surgical Office reports.

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

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

EOC

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

We inspected the emergency department, the CLC, the intensive care unit, the inpatient medical/surgical unit, primary care, the x-ray and fluoroscopy areas, and the acute MH unit. Additionally, we reviewed relevant documents, conversed with key employees and managers, and reviewed 28 employee training records (9 radiology employees, 10 acute MH unit employees, 4 Multidisciplinary Safety Inspection Team members, and 5 occasional acute MH unit employees). The table below shows the areas reviewed for this topic. Any items that did not apply to this facility are marked NA. The facility generally met requirements. We made no recommendations.

NM	Areas Reviewed for General EOC	Findings
	EOC Committee minutes reflected sufficient detail regarding identified deficiencies, corrective actions taken, and tracking of corrective actions to closure.	
	An infection prevention risk assessment was conducted, and actions were implemented to address high-risk areas.	
	Infection Prevention/Control Committee minutes documented discussion of identified problem areas and follow-up on implemented actions and included analysis of surveillance activities and data.	
	Fire safety requirements were met.	
	Environmental safety requirements were met.	
	Infection prevention requirements were met.	
	Medication safety and security requirements were met.	
	Auditory privacy requirements were met.	
	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.	
	Areas Reviewed for Radiology	
	The facility had a Radiation Safety Committee, the committee met at least every 6 months and established a quorum for meetings, and the Radiation Safety Officer attended meetings.	
	Radiation Safety Committee meeting minutes reflected discussion of any problematic areas, corrective actions taken, and tracking of corrective actions to closure.	

NM	Areas Reviewed for Radiology (continued)	Findings
	Facility policy addressed frequencies of equipment inspection, testing, and maintenance.	
	The facility had policy for the safe use of fluoroscopic equipment.	
	The facility Director appointed a Radiation Safety Officer to direct the radiation safety program.	
	X-ray and fluoroscopy equipment items were tested by a qualified medical physicist before placed in service and annually thereafter, and quality control was conducted on fluoroscopy equipment in accordance with facility policy/procedure.	
	Designated employees received initial radiation safety training and training thereafter with the frequency required by local policy, and radiation exposure monitoring was completed for employees within the past year.	
	Environmental safety requirements in x-ray and fluoroscopy were met.	
	Infection prevention requirements in x-ray and fluoroscopy were met.	
	Medication safety and security requirements in x-ray and fluoroscopy were met.	
	Sensitive patient information in x-ray and fluoroscopy was protected.	
	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.	
	Areas Reviewed for Acute MH	
	MH EOC inspections were conducted every 6 months.	
	Corrective actions were taken for environmental hazards identified during inspections, and actions were tracked to closure.	
	MH unit staff, Multidisciplinary Safety Inspection Team members, and occasional unit workers received training on how to identify and correct environmental hazards, content and proper use of the MH EOC Checklist, and VA's National Center for Patient Safety study of suicide on psychiatric units.	

NM	Areas Reviewed for Acute MH (continued)	Findings
	The locked MH unit was 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.	

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. 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	Clinicians conducted inpatient learning assessments within 24 hours of admission or earlier if required by local policy.	• Thirty-two patients (91 percent) did not have documented learning needs assessments.
	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.	

Recommendation

6. We recommended that processes be strengthened to ensure that patient learning assessments are conducted and documented and that compliance be monitored.

Coordination of Care

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

We reviewed relevant documents, and we conversed with key employees. Additionally, we reviewed the EHRs of 32 randomly selected patients with specific diagnoses who were discharged from July 1, 2012, through June 30, 2013. The table below shows the areas reviewed for this topic. The areas marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

NM	Areas Reviewed	Findings
	Patients' post-discharge needs were identified, and discharge planning addressed the identified needs.	
X	Clinicians provided discharge instructions to patients and/or caregivers and validated their understanding.	• Twelve EHRs (38 percent) did not contain evidence that patients and/or caregivers were provided with discharge instructions related to restricted/special diets, wound care/dressing changes, and/or prosthetics. • Of the 13 patients who received discharge instructions for wound care, 4 EHRs did not contain documentation that clinicians validated patients' and/or caregivers' understanding of the discharge instructions they provided.
X	Patients received the ordered aftercare services and/or items within the ordered/expected timeframe.	• Six patients (19 percent) did not receive the services and/or items ordered within the ordered/expected timeframe.
X	Patients' and/or caregivers' knowledge and learning abilities were assessed during the inpatient stay.	• Thirty-one patients (97 percent) did not have documented learning needs assessments. Because we had a similar finding in the medication management review, we did not make a recommendation here.
	The facility complied with any additional elements required by VHA or local policy.	

Recommendations

7. We recommended that processes be strengthened to ensure that clinicians provide discharge instructions on all aftercare needs to patients and/or caregivers and document this in the EHR and that compliance be monitored.

8. We recommended that processes be strengthened to ensure that clinicians validate patients' and/or caregivers' understanding of the discharge instructions they provide.

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

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 40 training files, and we conversed with key employees. Additionally, we reviewed the actual nursing hours per patient day for 3 randomly selected units—acute medical/surgical unit 3S, the CLC nursing home care unit, and the MH inpatient behavioral health unit—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, 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 a pressure ulcer 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 3 of the 15 EHRs, staff did not consistently document the location, stage, risk scale score, and/or date acquired.
	Required activities were performed for patients determined to be at risk for pressure ulcers and for patients with pressure ulcers.	
	Required activities were performed for patients determined to not be at risk for pressure ulcers.	
	For patients at risk for and with pressure ulcers, interprofessional treatment plans were developed, interventions were recommended, and EHR documentation reflected that interventions were provided.	
	If the patient's pressure ulcer was not healed at discharge, a wound care follow-up plan was documented, and the patient was provided appropriate dressing supplies.	

NM	Areas Reviewed (continued)	Findings
X	The facility defined requirements for patient and caregiver pressure ulcer education, and education on pressure ulcer prevention and development was provided to those at risk for and with pressure ulcers and/or their caregivers.	Facility pressure ulcer patient and caregiver education requirements reviewed: • For 2 of the applicable 14 patients with a pressure ulcer, EHRs did not contain evidence that education was provided.
	The facility defined requirements for staff pressure ulcer education, and acute care staff received training on how to administer the pressure ulcer risk scale, conduct the complete skin assessment, and accurately document findings.	
	The facility complied with selected fire and environmental safety, infection prevention, and medication safety and security requirements in pressure ulcer patient rooms.	
	The facility complied with any additional elements required by VHA or local policy.	

Recommendations

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 provide and document pressure ulcer education for patients with pressure ulcers and/or their caregivers 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 31 residents during 2 meal periods, reviewed 10 employee training/competency records and other relevant documents, and conversed with key employees. The table below shows the areas reviewed for this topic. The areas marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

NM	Areas Reviewed	Findings
	The facility offered restorative nursing services.	
	Facility staff completed and documented restorative nursing services, including active and passive range of motion, bed mobility, transfer, and walking activities, according to clinician orders and residents' care plans.	
X	Resident progress towards restorative nursing goals was documented, and interventions were modified as needed to promote the resident's accomplishment of goals.	• In 2 EHRs, there was no evidence that facility staff documented resident progress towards restorative nursing goals.
	When restorative nursing services were care planned but were not provided or were discontinued, reasons were documented in the EHR.	
	If residents were discharged from physical therapy, occupational therapy, or kinesiotherapy, there was hand-off communication between Physical Medicine and Rehabilitation Service and the CLC to ensure that restorative nursing services occurred.	
X	Training and competency assessment were completed for staff who performed restorative nursing services.	• Two employee training/competency records did not contain evidence of completed training and competency assessment for range of motion. • Seven employee training/competency records did not contain evidence of completed training for resident transfers.
	The facility complied with any additional elements required by VHA or local policy.	

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

Recommendations

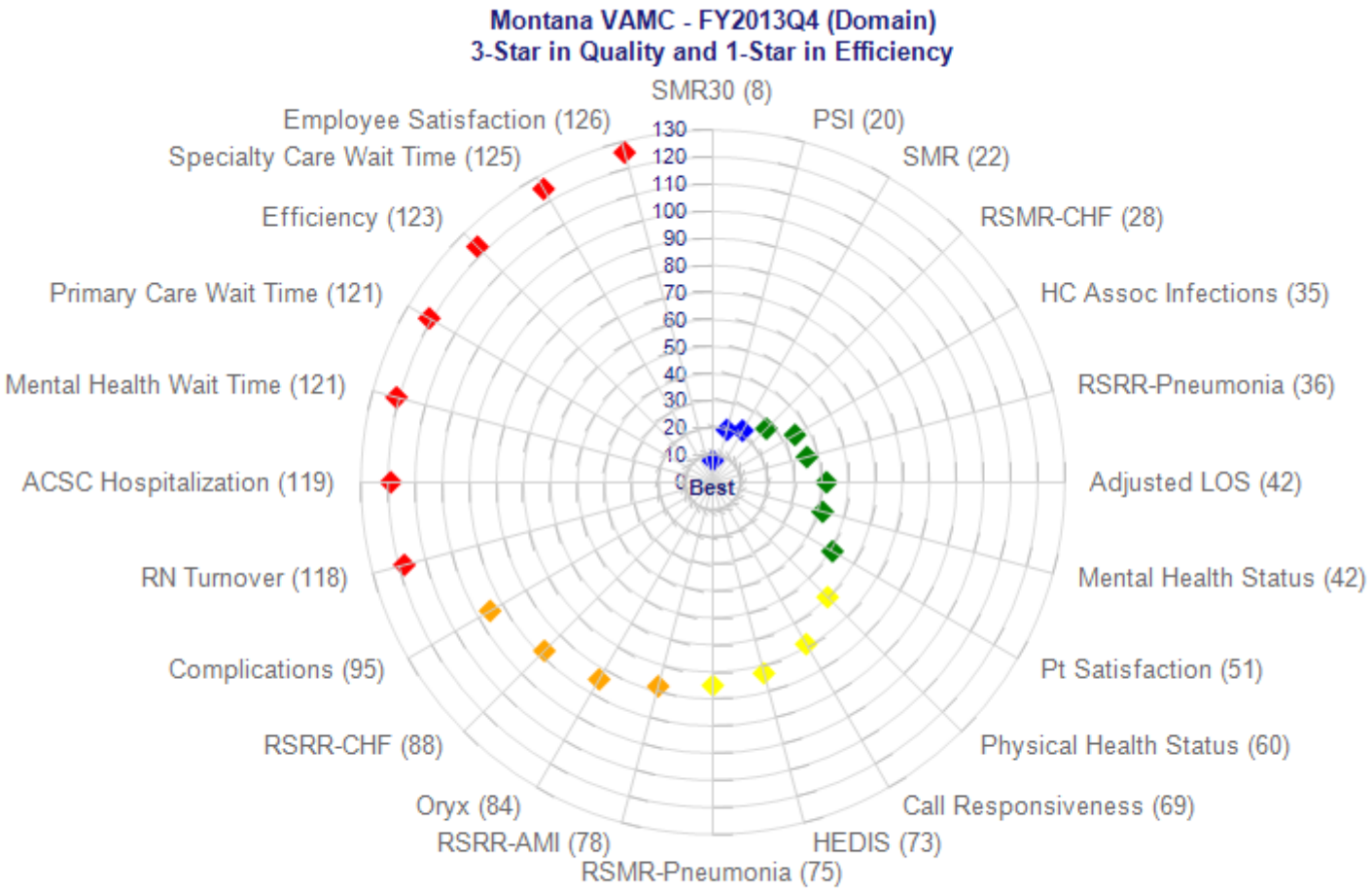
12. We recommended that processes be strengthened to ensure that staff document resident progress towards restorative nursing goals and that compliance be monitored.

13. We recommended that processes be strengthened to ensure that employees who perform restorative nursing services receive training on and competency assessment for range of motion and resident transfers.

Facility Profile (Fort Harrison/436) 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	$222.6
Number of:	
• **Unique Patients**	30,270
• **Outpatient Visits**	193,870
• **Unique Employees**[b]	908
Type and Number of Operating Beds (February 2014):	
• **Hospital**	53
• **CLC**	30
• **MH**	16
Average Daily Census:	
• **Hospital**	24
• **CLC**	25
• **MH**	11
Number of Community Based Outpatient Clinics	12
Location(s)/Station Number(s)	Anaconda/436GA Great Falls/436GB Missoula/436GC Bozeman/436GD Kalispell/436GF Billings/436GH Glasgow/436GI Miles City/436GJ Glendive/436GK Cut Bank/436GL Lewistown/436GM Havre/436HC
VISN Number	19

[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.

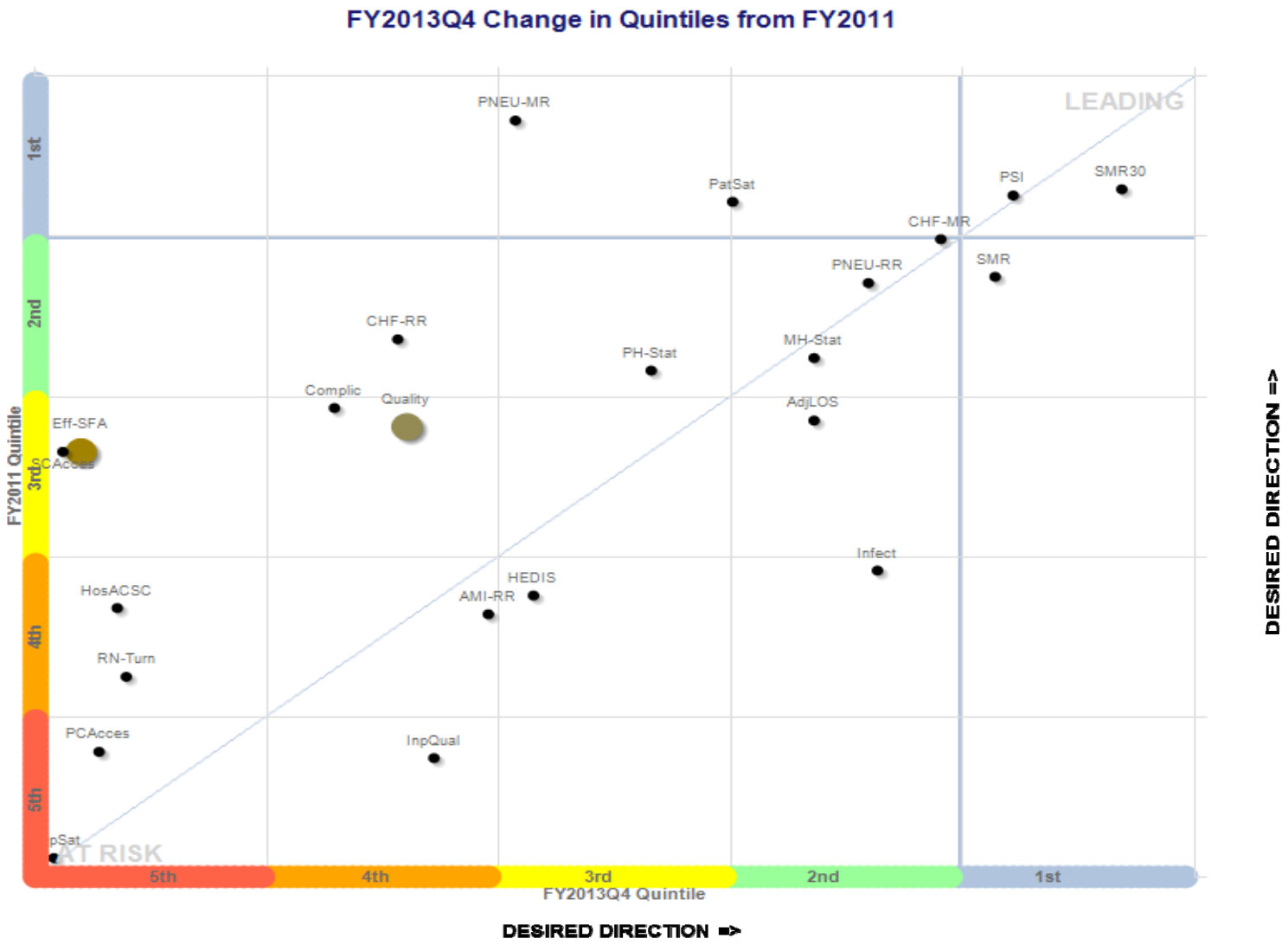
Strategic Analytics for Improvement and Learning (SAIL)[c]



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 21, 2014

From: Director, Rocky Mountain Network (10N19)

Subject: **CAP Review of the VA Montana Health Care System, Fort Harrison, MT**

To: Director, Seattle Office of Healthcare Inspections (54SE)

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

1. Thank you for the opportunity to respond to the proposed recommendations from the Combined Assessment Program Review completed March 4–7, 2014, at the VA Montana Health Care System, Fort Harrison, Montana.
2. In reviewing the proposed recommendations, the facility has addressed all identified deficiencies and has a plan to resolve all non-compliant areas cited in the report. Network 19 concurs with the report.
3. If you have any questions regarding this response, please contact Ms. Susan Curtis, VISN 19 HSS at (303) 639-6995.

(original signed by:)
Ralph T. Gigliotti, FACHE

Facility Director Comments

Department of Veterans Affairs **Memorandum**

Date: April 16, 2014

From: Director, VA Montana Health Care System (436/00)

Subject: **CAP Review of the VA Montana Health Care System, Fort Harrison, MT**

To: Director, Rocky Mountain Network (10N19)

1. Thank you for the opportunity to review the report on the Office of Inspector General Combined Assessment Program Review at the VA Montana Health Care System, Fort Harrison, Montana during the week of March 4–7, 2014. We concur with the findings and recommendations and will ensure that actions to correct them are completed as described.
2. Please find attached our facility responses to each recommendation, including the status of the corrective action plans.
3. If you have any questions regarding this response, please contact Ms. Edna Clausen at (406) 447-7312.

(original signed by:)
Christine Gregory, FACHE
Director, VA Montana Health Care System (436/00)

Comments to OIG's Report

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

Recommendations

Recommendation 1. We recommended that the MEC document its discussion of unusual findings or patterns from PRC quarterly summary reports.

Concur

Target date for completion: August 2014

Facility response: The Risk Management report will include system issues, unusual findings or patterns, and open peer review items from the Peer Review Committee (PRC) and will be presented to the Medical Executive Committee (MEC) quarterly for discussion. The Chief of Staff will ensure the MEC minutes reflect the discussion of the PRC findings. The Risk Manager will monitor the MEC minutes to ensure accurate reflection of the discussion regarding PRC reporting.

Recommendation 2. We recommended that processes be strengthened to ensure that the Cardiopulmonary Resuscitation Committee reviews each code episode and that code reviews include screening for clinical issues prior to the code that may have contributed to the occurrence of the code.

Concur

Target date for completion: September 2014

Facility response: The facility utilizes a code critique sheet to report all code blue events. The critique sheet reflects the code process and identifies issues with the process, equipment or supplies. This critique is initially screened by the ICU Nurse Manager and is to be brought to the CRC Committee for inclusion in the code blue discussion. The Cardiopulmonary Resuscitation Committee (CRC) members will be provided the names of the patients for which code blue events occurred during the quarter with the agenda for the meeting. Members of the CRC Committee have been educated on the updated review process and are expected to review the medical record for each identified patient paying particular attention to clinical issues prior to the code that may have contributed to the occurrence of the code. Discussion of each code event will occur in the CRC Committee and be reflected in the meeting minutes. The Quality Management Department will monitor the CRC meeting minutes quarterly and report results to the Healthcare Quality, Safety, and Value Executive Committee.

Recommendation 3. We recommended that the facility have a Surgical Work Group that meets monthly, includes the COS as a member, and documents its review of National Surgical Office reports.

Concur

Target date for completion: July 2014

Facility response: The Surgical Work Group has been scheduled to meet monthly beginning in April 2014. Members of the Group at a minimum include the Chief of Surgery as chairperson, Chief of Staff, OR Nurse Manager and the VASQIP Review Nurse. A standardized agenda is being developed to include all required review items form VHA Handbook 1102.01. Findings and results of the Surgical Work Group will be reported to the MEC.

Recommendation 4. We recommended that processes be strengthened to ensure that all surgical deaths are tracked and reviewed by appropriate clinical staff.

Concur

Target date for completion: August 2014

Facility response: The Risk Manager has been identifying surgical deaths as part of the Risk Morbidity and Mortality reporting and including these deaths in the facility peer review process. The Surgical Service has not however consistently completed M&M reviews on every surgical death. The Risk Manager will refer the names of all surgical deaths to the Chief of Surgery for inclusion in an M&M review to be completed within the following month. Minutes of these reviews will be documented and results of findings will be reported in the monthly Surgical Work Group meetings. The Risk Manager will conduct auditing of surgical M&Ms and include the findings in the quarterly Risk Management report to the MEC.

Recommendation 5. 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: September 2014

Facility response: Medical record review processes, tools, and reporting requirements for all clinical services have been in place for some time. The results of these reviews have been maintained in an excel spreadsheet and follow outs are shared with the individual service chiefs. Results of the ongoing monitoring have not been aggregated, trended or discussed in depth at the Medical Records Review Committee (MRRC). Analysis of medical record reviews that are less than 100% acceptable will be aggregated, discussed, and documented at the quarterly MRRC meeting beginning with 2nd quarter FY14. The MRRC auditing results will be reported to the MEC.

Recommendation 6. We recommended that processes be strengthened to ensure that patient learning assessments are conducted and documented and that compliance be monitored.

Concur

Target date for completion: August 2014

Facility response: A Learning Needs Assessment (LNA) was added to the Nursing Admission template and the Observation Nursing Admit template in January 2014. Staff were educated regarding the need and reasons for completing a LNA as well as identifying actions taken to accommodate barriers. A review of learning needs from the admission note and an update to barriers and needs identified field were added to the "discharge planning interdisciplinary" note as well. A sampling of medical records was audited in February with 79% compliance with a LNA including barriers to learning identified. Auditing in March resulted in 98% compliance with the LNA. Monitoring will continue monthly for 4 months to ensure sustained compliance and then will be done randomly thereafter.

Recommendation 7. We recommended that processes be strengthened to ensure that clinicians provide discharge instructions on all aftercare needs to patients and/or caregivers and document this in the EHR and that compliance be monitored.

Concur

Target date for completion: September 2014

Facility response: Discharge instruction processes are being updated to ensure patients' identified post-discharge needs are included in the discharge instructions. Discharge Instructions templates are being updated to include all elements required by VHA policy. All applicable inpatient staff will be educated on the updated discharge instruction processes, discharge instruction requirements in VHA and facility policies, and the revised templates.

Compliance with requirements for discharge instructions to be consistent with patients' identified post-discharge needs and to include all elements mandated by VHA policy will be monitored monthly beginning in June 2014. Monthly audits will continue until greater than 90% compliance is sustained and then will be completed randomly thereafter. Monthly auditing results will be reported to the MEC.

Recommendation 8. We recommended that processes be strengthened to ensure that clinicians validate patients' and/or caregivers' understanding of the discharge instructions they provide.

Concur

Target date for completion: September 2014

Facility response: All applicable inpatient staff will be educated on the need to document a patient response to the understanding of the discharge instructions provided. The patient response can be documented in the Nurse Discharge Summary, the Physician's Discharge Summary or any other discharge note. The Post Discharge Telephone Contact process continues to improve to include questions of whether or not the patient received discharge instructions, medications and equipment/supplies. Patient concerns and questions are answered at the time of the call or referred to the appropriate person for follow-up. Patients are also encouraged to call for any further questions or concerns.

Compliance with documenting the patient's understanding of discharge instructions will be monitored monthly beginning in June 2014 and will continue until greater than 90% compliance is sustained and then will be completed randomly thereafter. Monthly auditing results will be reported to the Medical Records Review Committee.

Recommendation 9. We recommended that processes be strengthened to ensure that patients receive ordered aftercare services and/or items within the ordered/expected timeframe.

Concur

Target date for completion: September 2014

Facility response: A Nursing discharge Summary template is being developed and will include identifying items ordered for aftercare, whether the items were provided at time of discharge or expected time frame for delivery. The post discharge phone call will include questions regarding receipt of supplies, equipment and/or treatments and whether there are any questions regarding the supplies, equipment, or treatments. Those items not received at time of discharge phone call will be tagged for another follow-up phone call. All information will be documented in the electronic medical record.

Compliance with documenting the patient's receipt of items ordered for aftercare will be monitored monthly by a sampling of discharges beginning in June 2014 and will continue until greater than 90% compliance is sustained and then will be completed randomly thereafter. Monthly auditing results will be reported to the Medical Records Review Committee.

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: September 2014

Facility response: Education was provided to the 3rd and 4th floor staff on 3/14 and 3/21 by the Certified Wound Care Nurse (CWCN) which included elements of pressure ulcer staging, location, risk scale score, and specific dates of treatment. A wound care resource wall which includes skin tear information along with wound and ulcer staging information was placed on the medical and surgical floors for staff to refer to. The Inpatient Care Nurse Managers or designee and/or the wound care coordinator will audit 100% of hospital acquired pressure ulcers and at least 10% of pressure ulcers that present on admission for staging, location, risk scale score and specific dates of treatment. Audits will be done monthly for 4 months or until 90% compliance is sustained and then randomly thereafter. These results will be reported to the Program Assembly Committee in Patient Care Services with the first report due on 06/01/2014.

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

Concur

Target date for completion: September 2014

Facility response: A review of the wound care template is being completed by the CWCN and wound care team/stakeholders/HPDP to determine appropriate location for documentation of patient education. Once consensus is reached the template will be modified to reflect the education provided to patients and/or their caregivers for pressure ulcer education. Staff will be educated on the changes at staff meetings and through e-mails. Audits will be done monthly for 4 months or until 90% compliance is sustained and then randomly thereafter. These results will be reported to the Program Assembly Committee in Patient Care Services with the first report due on 06/01/2014.

Recommendation 12. We recommended that processes be strengthened to ensure that staff document resident progress towards restorative nursing goals and that compliance be monitored.

Concur

Target date for completion: September 2014

Facility response: The Restorative RN will develop and implement a templated note to document restorative nursing services, patient progress, deterioration or maintenance, and the reason for any disruption to the restorative services. Applicable CLC staff will be educated on the need to complete restorative nursing services according to clinician orders and/or residents' care plans, updated procedures, and the new restorative nursing services note template.

Compliance audits will be maintained at 90% compliance for the next 4 months and then will be conducted randomly. Monthly auditing results will be reported to the Medical Records Review Committee.

Recommendation 13. We recommended that processes be strengthened to ensure that employees who perform restorative nursing services receive training on and competency assessment for range of motion and resident transfers.

Concur

Target date for completion: July 2014

Facility response: Training and competency assessments of range-of-motion (ROM) and safe resident transfer for all staff will be provided and completed by July 1, 2014. The physical therapist will provide new employee training and competency assessment for ROM and safe resident transfer during new employee orientation. Training and competency will be recorded in the employee's competency folder. The physical therapist will also conduct ongoing annual training and competency assessment for ROM and safe resident transfer. Monitoring will be conducted through the Education Service competency tracer process and reported to the Continuous Accreditation Readiness Committee quarterly.

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Endnotes

[1] References used for this topic included:
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