Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 14-00686-166

Combined Assessment Program Review of the Aleda E. Lutz VA Medical Center Saginaw, Michigan

May 27, 2014

Washington, DC 20420

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

Glossary

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

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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 10, 2014.

Review Results: The review covered seven activities and follow-up on recommendations from the previous Combined Assessment Program review. We made no recommendations in the following four activities:

- Quality Management
- Environment of Care
- Medication Management
- Coordination of Care

The facility's reported accomplishment was being recognized as one of the Most Wired health care systems in the country.

Recommendations: We made recommendations in the following three activities and in the follow-up areas:

Nurse Staffing: Fully implement the plan approved in March 2014. Include all required members on the facility expert panel and the acute care unit-based expert panel.

Pressure Ulcer Prevention and Management: Accurately document the risk scale score for all patients with pressure ulcers. Establish staff pressure ulcer education requirements. Initiate and complete wound care specialist consults for all patients with pressure ulcers.

Community Living Center Resident Independence and Dignity: Complete and document restorative nursing services according to residents' care plans, document residents' progress toward restorative nursing goals, and document residents' restorative progress bi-weekly.

Follow-Up Areas: Consult with Veterans Health Administration program managers regarding Sterile Processing Service humidity control issues, and follow recommended actions. Ensure all required participants or their designees attend weekly environment of care rounds.

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 21–26, for the full text of the Directors' comments.) We consider recommendations 1, 2, and 3 closed. We will follow up on the planned actions for the open recommendations until they are completed.

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

Objectives and Scope

Objectives

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

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

Scope

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

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

- 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 FYs 2011–2013 and FY 2014 through March 13, 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 Aleda E. Lutz VA Medical Center, Saginaw, Michigan,* Report No. 09-03276-154, May 18, 2010). We made repeat recommendations regarding SPS sterile storage humidity levels and EOC rounds attendance.

During this review, we presented crime awareness briefings for 93 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 180 responded. We shared summarized results with facility managers.

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

Reported Accomplishment

Most Wired Award

In 2013, the facility was recognized by *Hospitals and Health Networks* magazine as one of the Most Wired health care systems in the country. This recognition is awarded to health care systems that have exceeded industry benchmarks for the integration and utilization of information technology. As a result of the facility's enhanced information technology systems, during FY 2013, telehealth encounters increased from 1,128 to 14,473.

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. 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
	There was a senior-level committee/group responsible for QM/performance improvement that met regularly. • There was evidence that outlier data was acted upon. • There was evidence that QM, patient safety, and systems redesign were integrated.	
	The protected peer review process met selected requirements: • The PRC was chaired by the Chief of Staff and included membership by applicable service chiefs. • Actions from individual peer reviews were completed and reported to the PRC. • The PRC submitted quarterly summary reports to the MEC. • Unusual findings or patterns were discussed at the MEC.	
	Focused Professional Practice Evaluations for newly hired licensed independent practitioners were initiated and completed, and results were reported to the MEC.	
	Specific telemedicine services met selected requirements: • Services were properly approved. • Services were provided and/or received by appropriately privileged staff. • Professional practice evaluation information was available for review.	

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

NM	Areas Reviewed (continued)	Findings
	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.	

EOC

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

We inspected the acute care, the palliative care, the urgent care, and two CLC units; three primary care clinics; and the x-ray and nuclear medicine units. Additionally, we reviewed relevant documents, conversed with key employees and managers, and reviewed 10 radiology employees' training records. 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	
NA	MH EOC inspections were conducted every 6 months.	
NA	Corrective actions were taken for environmental hazards identified during inspections, and actions were tracked to closure.	
NA	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
NA	The locked MH unit(s) was/were in compliance with MH EOC Checklist safety requirements or an abatement plan was in place.	
NA	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 29 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 conversed with key employees. Additionally, we reviewed the EHRs of six 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 two inpatient units (acute medical/surgical and long-term care).[5]

We reviewed facility and unit-based expert panel documents and 11 training files, and we conversed with key employees. Additionally, we reviewed the actual nursing hours per patient day for 2 units—the acute medical/surgical unit and the CLC unit—for 50 randomly selected days between October 1, 2012, and September 30, 2013. The table below shows the areas reviewed for this topic. The areas marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

NM	Areas Reviewed	Findings
X	The facility either implemented or reassessed a nurse staffing methodology within the expected timeframes.	• The facility Director did not document approval of the nurse staffing methodology implementation plan until March 2014.
X	The facility expert panel followed the required processes and included the required members.	• The facility expert panel did not include evening and night supervisory staff, staff nurses and other nursing staff providing direct patient care, and a Labor Partner representative.
X	The unit-based expert panels followed the required processes and included the required members.	• The acute care unit-based expert panel did not include licensed practical nurses and nursing assistants.
	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.	

Recommendations

1. We recommended that nursing managers fully implement the plan approved in March 2014.

2. We recommended that the annual staffing plan reassessment process ensures that the facility expert panel includes all required members.

3. We recommended that the annual staffing plan reassessment process ensures that the acute care unit-based expert panel includes all required members.

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, 5 EHRs of 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.	
	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 two of the five EHRs, staff did not consistently document the risk scale score.
	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.	
	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.	

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.	
X	The facility complied with any additional elements required by VHA or local policy.	Local policies on pressure ulcer prevention and management and the consult process reviewed: • Local pressure ulcer policy requires that a wound care specialist consult be initiated for all patients with a pressure ulcer. In two of the five EHRs, wound care specialist consults were not initiated. • Local consult policy requires that all consultative services be completed during an inpatient admission. In two of the five EHRs, wound care specialist consults were not completed.

Recommendations

4. We recommended that processes be strengthened to ensure that acute care staff accurately document the risk scale score for all patients with pressure ulcers and that compliance be monitored.

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

6. We recommended that processes be strengthened to ensure that wound care specialist consults are initiated and completed for all patients with pressure ulcers 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 11 EHRs of residents (10 residents receiving restorative nursing services and 1 resident not receiving restorative nursing services but a candidate for services). We also observed 1 resident during 2 meal periods, reviewed 10 employee training/competency records and other relevant documents, and conversed with key employees. The table below shows the areas reviewed for this topic. The areas marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

NM	Areas Reviewed	Findings
	The facility offered restorative nursing services.	
X	Facility staff completed and documented restorative nursing services, including active and passive range of motion, bed mobility, transfer, and walking activities, according to clinician orders and residents' care plans.	• In 9 of the 10 applicable EHRs, there was no documentation that facility staff completed restorative nursing services according to 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 7 of the 10 applicable EHRs, there was no evidence that facility staff documented resident progress towards restorative nursing goals.
	When restorative nursing services were care planned but were not provided or were discontinued, reasons were documented in the EHR.	
	If residents were discharged from physical therapy, occupational therapy, or kinesiotherapy, there was hand-off communication between Physical Medicine and Rehabilitation Service and the CLC to ensure that restorative nursing services occurred.	
	Training and competency assessment were completed for staff who performed restorative nursing services.	
X	The facility complied with any additional elements required by VHA or local policy.	Local policy on restorative care program for CLC residents reviewed: • In 7 of the 10 applicable EHRs, there was no bi-weekly documentation regarding residents' restorative progress.

Recommendations

7. We recommended that processes be strengthened to ensure that staff complete and document restorative nursing services according to residents' care plans and that compliance be monitored.

8. We recommended that processes be strengthened to ensure that staff document residents' progress toward restorative nursing goals and that compliance be monitored.

9. We recommended that processes be strengthened to ensure that staff document residents' restorative progress bi-weekly and that compliance be monitored.

Follow-Up on Previous CAP Recommendations

As a follow-up to recommendations from our previous CAP review, we reassessed facility compliance with SPS sterile storage humidity levels and EOC rounds attendance.[8]

SPS Sterile Storage Humidity Levels. VHA requires SPS sterile storage humidity levels to be maintained between 20 and 60 percent. We reviewed humidity log readings for February 13–March 12, 2014, and found that 2,176 of 2,688 readings (81 percent) were under the 20 percent threshold.

EOC Rounds Attendance. VHA requires that the Director or Associate Director lead weekly EOC rounds. Managers in nursing, building management, engineering, safety, patient safety, and infection control must be included as well as the Information Security Officer and others, as required. We reviewed weekly EOC rounds and attendance rosters for 2 quarters and determined that rounds did not include all required participants or their designees.

Recommendations

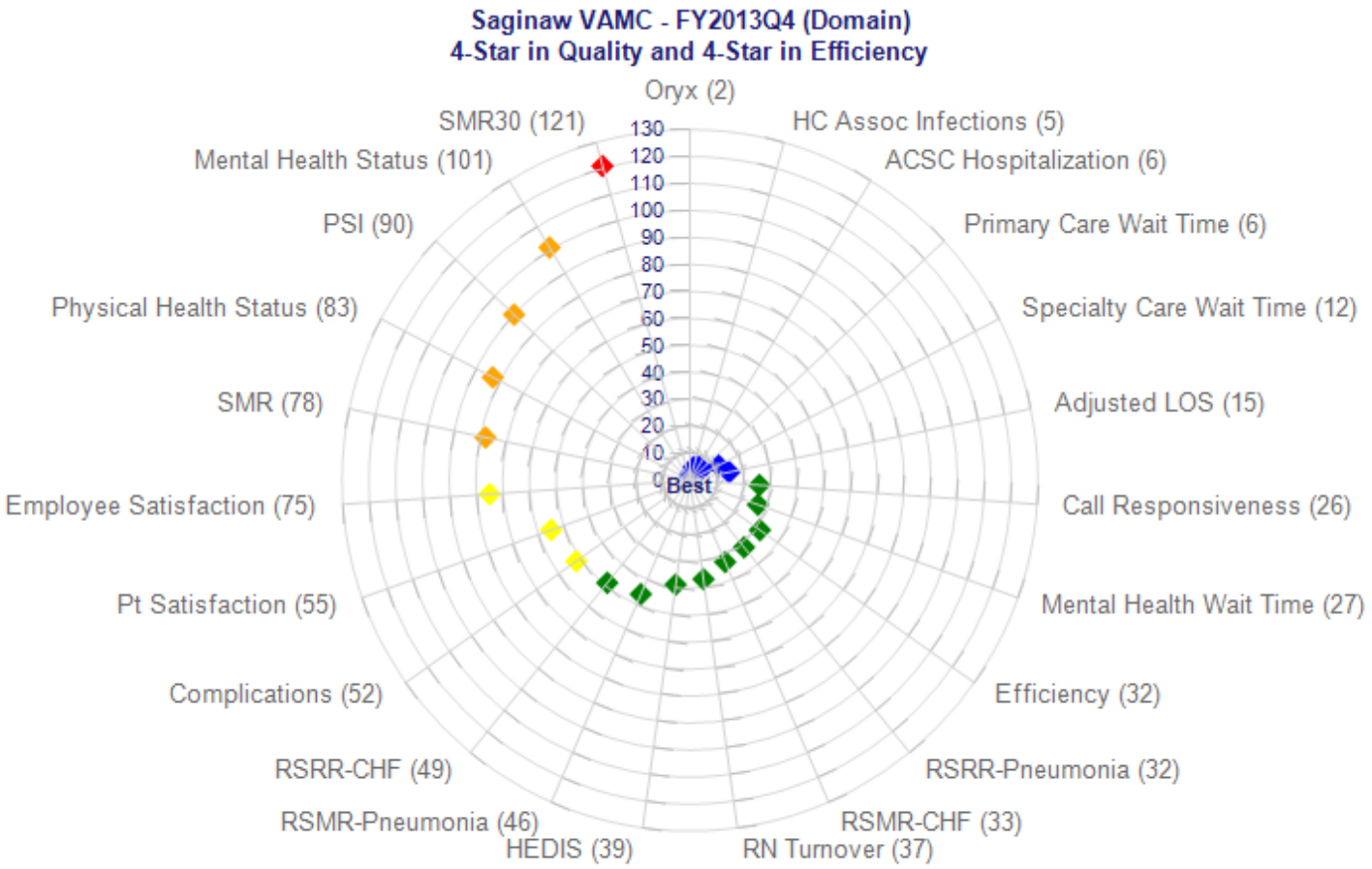
10. We recommended that the facility consult with VHA program managers regarding SPS humidity control issues and that recommended actions be followed.

11. We recommended that processes be strengthened to ensure that all required participants or their designees attend weekly EOC rounds and that compliance be monitored.

Facility Profile (Saginaw/655) FY 2014 through March 2014[a]	
Type of Organization	Non-intensive care unit
Complexity Level	3-Low complexity
Affiliated/Non-Affiliated	Affiliated
Total Medical Care Budget in Millions	$156.7
Number of:	
• **Unique Patients**	26,506
• **Outpatient Visits**	177,317
• **Unique Employees**[b]	788
Type and Number of Operating Beds (February 2014):	
• **Hospital**	19
• **CLC**	81
• **MH**	0
Average Daily Census:	
• **Hospital**	4
• **CLC**	38
• **MH**	NA
Number of Community Based Outpatient Clinics	9
Location(s)/Station Number(s)	Gaylord/655GA Traverse City/655GB Oscoda/655GC Alpena/655GD Clare County/655GE Bad Axe/655GF Cadillac/655GG Cheboygan/655GH Grayling/655GI
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.

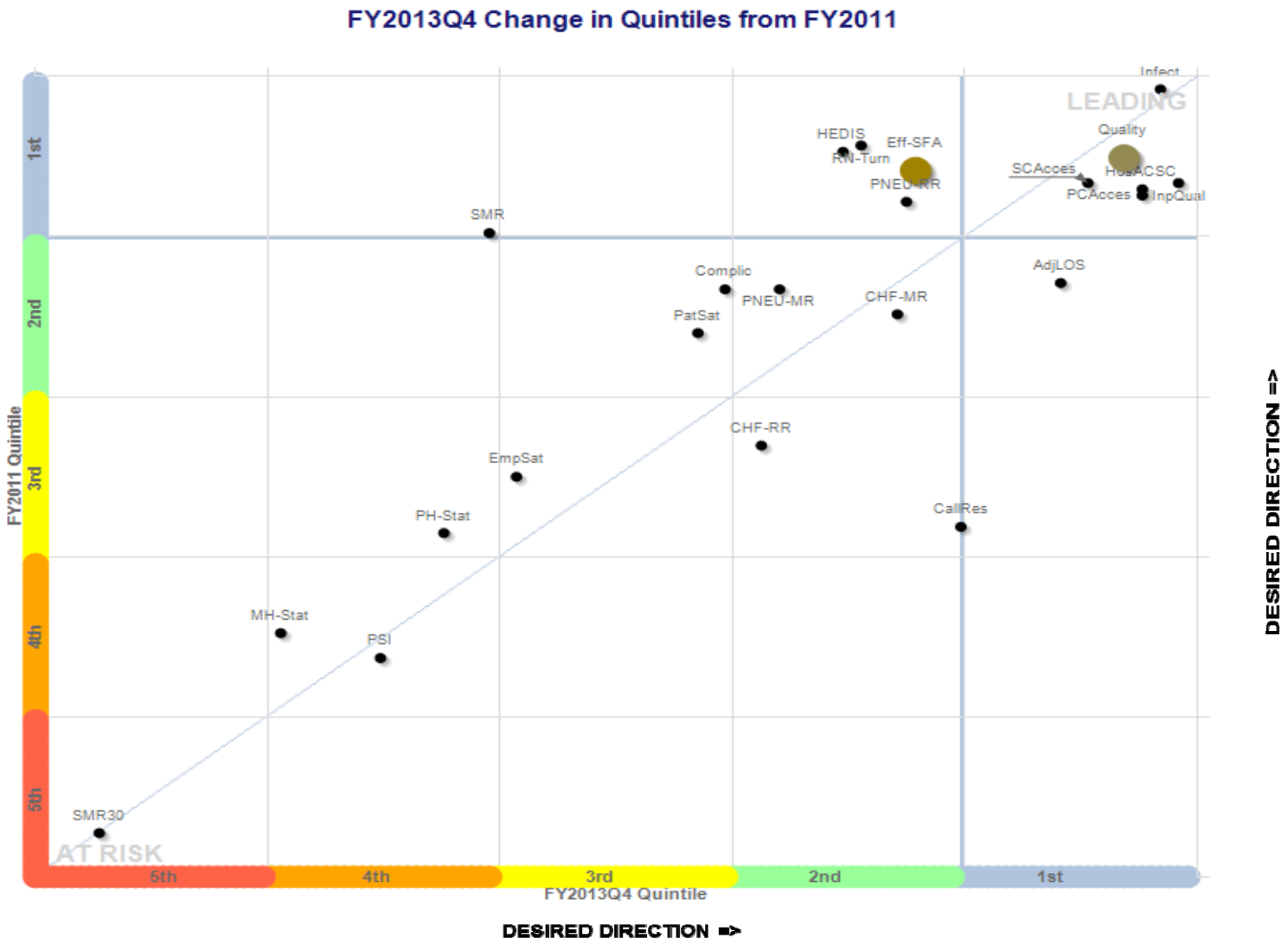
Strategic Analytics for Improvement and Learning (SAIL)[c]



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: May 1, 2014

From: Director, Veterans In Partnership (10N11)

Subject: **CAP Review of the Aleda E. Lutz VA Medical Center, Saginaw, MI**

To: Director, Chicago Office of Healthcare Inspections (54CH)

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

1. I concur with the findings and recommendations in the report of the CAP Review of the Aleda E. Lutz VA Medical Center, Saginaw, MI.

2. If you have any questions regarding the responses and actions to the recommendations, please contact me at 734-222-4300.

Thank you,

Paul Bockelman

Paul Bockelman, FACHE
Network Director

Facility Director Comments

Department of Veterans Affairs **Memorandum**

Date: May 1, 2014

From: Director, Aleda E. Lutz VA Medical Center (655/00)

Subject: **CAP Review of the Aleda E. Lutz VA Medical Center, Saginaw, MI**

To: Director, Veterans In Partnership (10N11)

I concur with the Aleda E. Lutz VA Medical Center's response and action plans as detailed within this report.

Peggy W. Kearns, MS, FACHE

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 nursing managers fully implement the plan approved in March 2014.

Concur

Target date for completion: April 14, 2014

Facility response: Full implementation of the Nurse Staffing Methodology Plan will be in place by April 14, 2014. Additional required members were added to both the Facility Expert Panel and the Community Living Center Unit Panel. All panel members have completed the Staffing Methodology for VHA Nursing Personnel course. Data collection processes are in place for each unit. The staffing methodology reassessment for each unit will be performed annually by the Nurse Managers and reported to the Quality Executive Board.

Recommendation 2. We recommended that the annual staffing plan reassessment process ensures that the facility expert panel includes all required members.

Concur

Target date for completion: March 13, 2014

Facility response: Facility Expert Action Panel includes all required members. Staff has completed the Staffing Methodology for VHA Nursing Personnel course.

Recommendation 3. We recommended that the annual staffing plan reassessment process ensures that the acute care unit-based expert panel includes all required members.

Concur

Target date for completion: March 12, 2014

Facility response: Acute Care Telemetry Unit Expert Panel includes all required members. The staff has completed the Staffing Methodology for VHA Nursing Personnel course.

Recommendation 4. We recommended that processes be strengthened to ensure that acute care staff accurately document the risk scale score for all patients with pressure ulcers and that compliance be monitored.

Concur

Target date for completion: December 31, 2014

Facility response: All inpatient nursing staff has been assigned an education module on how to complete the Braden scale. Thirty Braden scores will be reviewed each month for accuracy of documentation by the Nurse Managers. Reports will be reviewed at the Pressure Ulcer Committee and Quality Executive Board monthly.

Recommendation 5. We recommended that the facility establish staff pressure ulcer education requirements and that compliance be monitored.

Concur

Target date for completion: December 31, 2014

Facility response: All inpatient nursing staff has been assigned National Database of Nursing Quality Indicators modules which include how to assess skin and pressure ulcers and document findings. They have also been assigned module on the Braden scale. Nurse Managers to monitor compliance monthly. Reports will be reviewed at the Pressure Ulcer Committee and Quality Executive Board monthly.

Recommendation 6. We recommended that processes be strengthened to ensure that wound care specialist consults are initiated and completed for all patients with pressure ulcers and that compliance be monitored.

Concur

Target date for completion: December 31, 2014

Facility response: All admission assessments and new wound notes will be reviewed. For pressure ulcers identified in the admission assessment or new wound note, ensure that a consult is present for the wound specialist. Nurse Managers will monitor compliance for consults placed and completed monthly. Reports will be reviewed at the Pressure Ulcer Committee and Quality Executive Board monthly.

Recommendation 7. We recommended that processes be strengthened to ensure that staff complete and document restorative nursing services according to residents' care plans and that compliance be monitored.

Concur

Target date for completion: December 31, 2014

Facility response: The Activities of Daily Living (ADL) note will be revised to enable documentation of residents' care plan goals pertaining to restorative care. Staff will be educated on the new process. Restorative Nurse Coordinator (RNC) will monitor compliance monthly. Reports will be reviewed at the Quality Executive Board monthly.

Recommendation 8. We recommended that processes be strengthened to ensure that staff document residents' progress toward restorative nursing goals and that compliance be monitored.

Concur

Target date for completion: December 31, 2014

Facility response: The Activities of Daily Living (ADL) note will be revised to enhance documentation of residents' progress towards restorative goals. Staff will be educated by the RNC. The RNC will monitor compliance monthly. Reports will be reviewed at the Quality Executive Board monthly.

Recommendation 9. We recommended that processes be strengthened to ensure that staff document residents' restorative progress bi-weekly and that compliance be monitored.

Concur

Target date for completion: December 31, 2014

Facility response: Re-educate all nursing staff to refer to restorative orders in Kardex to guide documentation of progress toward goals. The RNC will monitor compliance monthly. Reports will be reviewed at the Quality Executive Board monthly.

Recommendation 10. We recommended that the facility consult with VHA program managers regarding SPS humidity control issues and that recommended actions be followed.

Concur

Target date for completion: June 30, 2014

Facility response: The National SPS group has been consulted as to their practice when humidity controls fall outside the recommended levels. Humidity levels will continue to be monitored. SPS staff are visually inspecting packages prior to leaving the SPS area and during distribution of the packages. Clinic areas inspect all packages prior to use. The policy for Sterilization, Disinfection, and Cleaning will be modified to reflect the visual monitoring activity. Attestation memo will be completed monthly by the Sterile Processing Service Supervisor verifying that packages have been inspected daily and reported to Quality Executive Board monthly.

Recommendation 11. We recommended that processes be strengthened to ensure that all required participants or their designees attend weekly EOC rounds and that compliance be monitored.

Concur

Target date for completion: December 31, 2014

Facility response: MCM 00-44, Hazard Surveillance was sent for first level concurrence on April 2, 2014. Clarification was made to ensure that Building Maintenance and Engineering are always represented at every hazard surveillance inspection. This will be documented through the hazard surveillance attendance and reported to Quality Executive Board monthly.

OIG Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the OIG at (202) 461-4720.
Onsite Contributors	Debra Boyd-Seale, RN, PhD, Team Leader Sheila Cooley, GNP, MSN Wachita Haywood, RN Laura Spottiswood, RN, MPH Ann Ver Linden, RN, MBA Gregg Hirstein, BS, Special Agent in Charge, Office of Investigations
Other Contributors	Judy Brown Elizabeth Bullock Shirley Carlile, BA Paula Chapman, CTRS Lin Clegg, PhD Marnette Dhooghe, MS Matt Frazier, MPH Jeff Joppie, BS Victor Rhee, MHS Julie Watrous, RN, MS Jarvis Yu, MS

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Endnotes

[1] References used for this topic included:
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[4] References used for this topic included:
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