Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 14-02063-231

Combined Assessment Program Review of the New Mexico VA Health Care System Albuquerque, New Mexico

July 31, 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
EHR	electronic health record
EOC	environment of care
facility	New Mexico VA Health Care System
FY	fiscal year
MEC	Medical Executive Committee
MH	mental health
MRI	magnetic resonance imaging
NA	not applicable
NM	not met
OIG	Office of Inspector General
PACU	post-anesthesia care unit
PRC	Peer Review Committee
QM	quality management
SDS	same day surgery
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. We conducted the review the week of June 2, 2014.

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

- Medication Management
- Coordination of Care
- Community Living Center Resident Independence and Dignity
- Magnetic Resonance Imaging Safety

The facility's reported accomplishments were improvements in blood transfusion processes and the prevention of hospital-acquired infections.

Recommendations: We made recommendations in the following three activities:

Quality Management: Consistently initiate Focused Professional Practice Evaluations for newly hired licensed independent practitioners. Perform continuing stay reviews on at least 75 percent of patients in acute beds. Require that the blood/transfusion usage review process includes the results of proficiency testing and the results of peer reviews when transfusions did not meet criteria. Ensure actions taken when data analyses indicated problems or opportunities for improvement are consistently followed to resolution for outlier data, bar code scanning, and blood transfusions.

Environment of Care: Ensure nurse call system alarms are functional.

Acute Ischemic Stroke Care: Complete and document National Institutes of Health stroke scales for each stroke patient. Post stroke guidelines in the emergency department, on the critical care units, and on the medical and surgical units. Provide printed stroke education to patients upon discharge. Ensure staff who are involved in assessing and treating stroke patients receive the training required by the facility.

Comments

The Acting Veterans Integrated Service Network Director and Interim Facility Director agreed with the Combined Assessment Program review findings and recommendations

and provided acceptable improvement plans. (See Appendixes C and D, pages 18–22, 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

Objective

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 objective of the CAP review is to conduct recurring evaluations of selected health care facility operations, focusing on patient care quality and the EOC.

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
- Acute Ischemic Stroke Care
- CLC Resident Independence and Dignity
- MRI Safety

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 June 2, 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 New Mexico VA Health Care System, Albuquerque, New Mexico,* Report No. 12-00881-203, June 19, 2012).

We surveyed employees regarding patient safety and quality of care at the facility. An electronic survey was made available to all facility employees, and 474 responded. We shared summarized results with facility managers.

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

Reported Accomplishments

Improving Provider Transfusion Practice

The facility's surgical service team improved provider transfusion practice by implementing a revised transfusion audit tool and process with provider-specific feedback and initiating review of aggregated quarterly data by surgical sub-specialty. The 3rd quarter 2013 review indicated a 96 percent compliance with transfusion orders having appropriate indication documented, a 71 percent compliance with transfusions having outcome documented, and a 69 percent compliance with transfusions having an appropriate note. The transfusion utilization rate dropped 11 percent for orthopedic procedures and 13 percent for general surgery procedures. The auditing tool and process will be used in other surgical sub-specialties and services using blood products.

Hospital-Acquired Infections

The facility improved housekeeping employee training in order to prevent hospital-acquired infections caused by *Clostridium difficile*, a bowel bacteria most frequently identified in patients with antibiotic hospital-acquired diarrhea. Step-by-step training that included housekeeping tasks and responsibilities, classroom training, videos, on-the-job training, and hands on demonstrations was completed by 4th quarter 2013. As a result of improved housekeeping, relative light units, which measure the energy source present in any bacteria, have been significantly reduced since January 2013 from 14,500 to 500.

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.[a]

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

NM	Areas Reviewed	Findings
	There was a senior-level committee/group responsible for QM/performance improvement that met regularly. • There was evidence that outlier data was acted upon. • There was evidence that QM, patient safety, and systems redesign were integrated.	
	The protected peer review process met selected requirements: • The PRC was chaired by the Chief of Staff and included membership by applicable service chiefs. • Actions from individual peer reviews were completed and reported to the PRC. • The PRC submitted quarterly summary reports to the MEC. • Unusual findings or patterns were discussed at the MEC.	
X	Focused Professional Practice Evaluations for newly hired licensed independent practitioners were initiated and completed, and results were reported to the MEC.	Thirty-two profiles reviewed: • Four Focused Professional Practice Evaluations (13 percent) were not initiated.
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.	
X	Staff performed continuing stay reviews on at least 75 percent of patients in acute beds.	Twelve months of continuing stay data reviewed: • For all months, less than 75 percent of acute inpatients were reviewed.
	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. • Surgical deaths with identified problems or opportunities for improvement were reviewed. • Additional data elements were routinely reviewed.	
	Critical incidents reporting processes were appropriate.	
	The process to review the quality of entries in the EHR met selected requirements: • A committee was responsible to review EHR quality. • Data were collected and analyzed at least quarterly. • Reviews included data from most services and program areas.	
	The policy for scanning non-VA care documents met selected requirements.	

NM	Areas Reviewed (continued)	Findings
X	The process to review blood/transfusions usage met selected requirements: • A committee with appropriate clinical membership met at least quarterly to review blood/transfusions usage. • Additional data elements were routinely reviewed.	Four quarters of Blood Usage Review Committee meeting minutes reviewed: • The review process did not include the results of proficiency testing and the results of peer reviews when transfusions did not meet criteria.
X	Overall, if significant issues were identified, actions were taken and evaluated for effectiveness.	• Corrective actions were not consistently followed to resolution for outlier data, bar code scanning issues, or blood transfusion.
	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 Focused Professional Practice Evaluations for newly hired licensed independent practitioners are consistently initiated.

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

3. We recommended that processes be strengthened to ensure 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.

4. We recommended that processes be strengthened to ensure that actions taken when data analyses indicated problems or opportunities for improvement are consistently followed to resolution in outlier data, bar codes that were unable to scan, and blood transfusions.

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 the facility met selected requirements in SDS, the PACU, and the eye clinic.[b]

We inspected the medical, surgical, and locked inpatient MH units; the medical intensive care unit; the PACU; the CLC; the emergency department; and the primary care, renal, and eye clinics. Additionally, we reviewed relevant documents, conversed with key employees and managers, and reviewed 15 employee training records (10 PACU and 5 eye clinic). 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 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.	
X	Environmental safety requirements were met.	• Nurse call system alarms were not audible and/or visible in four of the eight patient care areas.
	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 SDS and the PACU	
NA for SDS	Designated SDS and PACU employees received bloodborne pathogens training during the past 12 months.	
NA	Designated SDS employees received medical laser safety training with the frequency required by local policy.	
NA for SDS	Fire safety requirements in SDS and on the PACU were met.	

NM	Areas Reviewed for SDS and the PACU (continued)	Findings
NA for SDS	Environmental safety requirements in SDS and on the PACU were met.	
NA	SDS medical laser safety requirements were met.	
NA for SDS	Infection prevention requirements in SDS and on the PACU were met.	
NA for SDS	Medication safety and security requirements in SDS and on the PACU were met.	
NA for SDS	Auditory privacy requirements in SDS and on the PACU were met.	
	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.	
	Areas Reviewed for Eye Clinic	
	Designated eye clinic employees received laser safety training with the frequency required by local policy.	
	Environmental safety requirements in the eye clinic were met.	
	Infection prevention requirements in the eye clinic were met.	
	Medication safety and security requirements in the eye clinic were met.	
	Laser safety requirements in the eye clinic were met.	
	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.	

Recommendation

5. We recommended that processes be strengthened to ensure that nurse call system alarms are functional 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.[c]

We reviewed relevant documents and conversed with key managers and employees. Additionally, we reviewed the EHRs of 31 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.[d]

We reviewed relevant documents and conversed with key employees. Additionally, we reviewed the EHRs of 31 randomly selected patients with specific diagnoses who were discharged from July 1, 2012, through June 30, 2013. The table below shows the areas reviewed for this topic. Any items that did not apply to this facility are marked NA. The facility generally met requirements. We made no recommendations.

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

Acute Ischemic Stroke Care

The purpose of this review was to determine whether the facility complied with selected requirements for the assessment and treatment of patients who had an acute ischemic stroke.[e]

We reviewed relevant documents, the EHRs of 42 randomly selected patients who experienced stroke symptoms, and 20 employee training records (10 emergency department, 5 medical intensive care unit, and 5 medical and surgical unit), and we conversed with key employees. We also conducted onsite inspections of the emergency department, two critical care units, and the medical and surgical units. 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's stroke policy/plan/guideline addressed all required items.	
X	Clinicians completed the National Institutes of Health stroke scale for each patient within the expected timeframe.	• Twelve of the 42 EHRs (29 percent) did not contain documented evidence of completed stroke scales.
	Clinicians provided medication (tissue plasminogen activator) timely to halt the stroke and included all required steps, and tissue plasminogen activator was in stock or available within 15 minutes.	
X	Stroke guidelines were posted in all areas where patients may present with stroke symptoms.	• Stroke guidelines were not posted in any of the areas.
	Clinicians screened patients for difficulty swallowing prior to oral intake of food or medicine.	
X	Clinicians provided printed stroke education to patients upon discharge.	• Thirty-two of the applicable 35 EHRs (91 percent) did not contain documentation that stroke education was provided to the patient/caregiver.
X	The facility provided training to staff involved in assessing and treating stroke patients.	• Staff in the medical and surgical units were not provided the facility's required training on assessing and treating stroke patients.
	The facility collected and reported required data related to stroke care.	
	The facility complied with any additional elements required by VHA or local policy.	

Recommendations

6. We recommended that processes be strengthened to ensure that clinicians complete and document National Institutes of Health stroke scales for each stroke patient and that compliance be monitored.

7. We recommended that stroke guidelines be posted in the emergency department, on the critical care units, and on the medical and surgical units.

8. We recommended that processes be strengthened to ensure that clinicians provide printed stroke education to patients upon discharge and that compliance be monitored.

9. We recommended that processes be strengthened to ensure that staff who are involved in assessing and treating stroke patients receive the training required by the facility and that compliance be monitored.

CLC Resident Independence and Dignity

The purpose of this review was to determine whether the facility 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.[f]

We reviewed three EHRs of residents receiving restorative nursing services. We also observed 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. 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 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	
NA	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.	

MRI Safety

The purpose of this review was to determine whether the facility ensured safety in MRI in accordance with VHA policy requirements related to: (1) staff safety training, (2) patient screening, and (3) risk assessment of the MRI environment.[g]

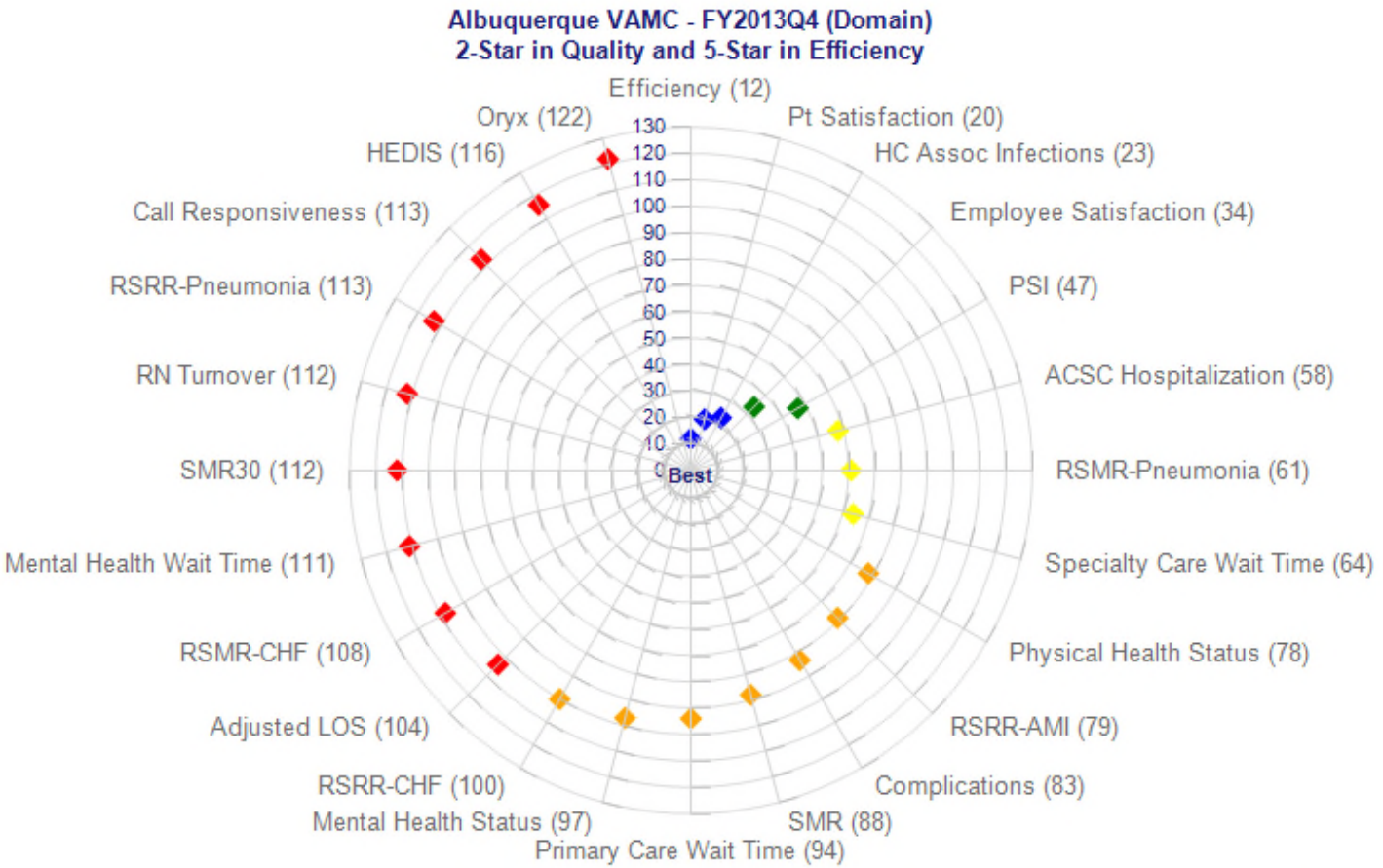
We reviewed relevant documents and the training records of 37 employees (30 randomly selected Level 1 ancillary staff and 7 designated Level 2 MRI personnel), and we conversed with key managers and employees. We also reviewed the EHRs of 35 randomly selected patients who had an MRI January 1–December 31, 2013. Additionally, we conducted physical inspections of two MRI areas. 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 completed an MRI risk assessment, there were documented procedures for handling emergencies in MRI, and emergency drills were conducted in the MRI area.	
	Two patient safety screenings were conducted prior to MRI, and the secondary patient safety screening form was signed by the patient, family member, or caregiver and reviewed and signed by a Level 2 MRI personnel.	
	Any MRI contraindications were noted on the secondary patient safety screening form, and a Level 2 MRI personnel and/or radiologist addressed the contraindications and documented resolution prior to MRI.	
	Level 1 ancillary staff and Level 2 MRI personnel were designated and received level-specific annual MRI safety training.	
	Signage and barriers were in place to prevent unauthorized or accidental access to Zones III and IV.	
	MRI technologists maintained visual contact with patients in the magnet room and two-way communication with patients inside the magnet, and the two-way communication device was regularly tested.	
	Patients were offered MRI-safe hearing protection for use during the scan.	
	The facility had only MRI-safe or compatible equipment in Zones III and IV, or the equipment was appropriately protected from the magnet.	
	The facility complied with any additional elements required by VHA or local policy.	

Facility Profile (Albuquerque/501) FY 2014 through June 2014[1]	
Type of Organization	Tertiary
Complexity Level	1a-High complexity
Affiliated/Non-Affiliated	Affiliated
Total Medical Care Budget in Millions	$413.8
Number of:	
• **Unique Patients**	56,428
• **Outpatient Visits**	439,758
• **Unique Employees**[2]	1,960
Type and Number of Operating Beds:	
• **Hospital**	167
• **CLC**	36
• **MH**	90
Average Daily Census (as of May 2014):	
• **Hospital**	118
• **CLC**	23
• **MH**	73
Number of Community Based Outpatient Clinics	12
Location(s)/Station Number(s)	Las Vegas/501G2 Artesia/501GA Farmington/501GB Silver City/501GC Gallup/501GD Espanola/501GE Truth or Consequences/501GH Alamogordo/501GI Durango/501GJ Santa Fe/501GK Rio Rancho/501GM Raton/501HB
VISN Number	18

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

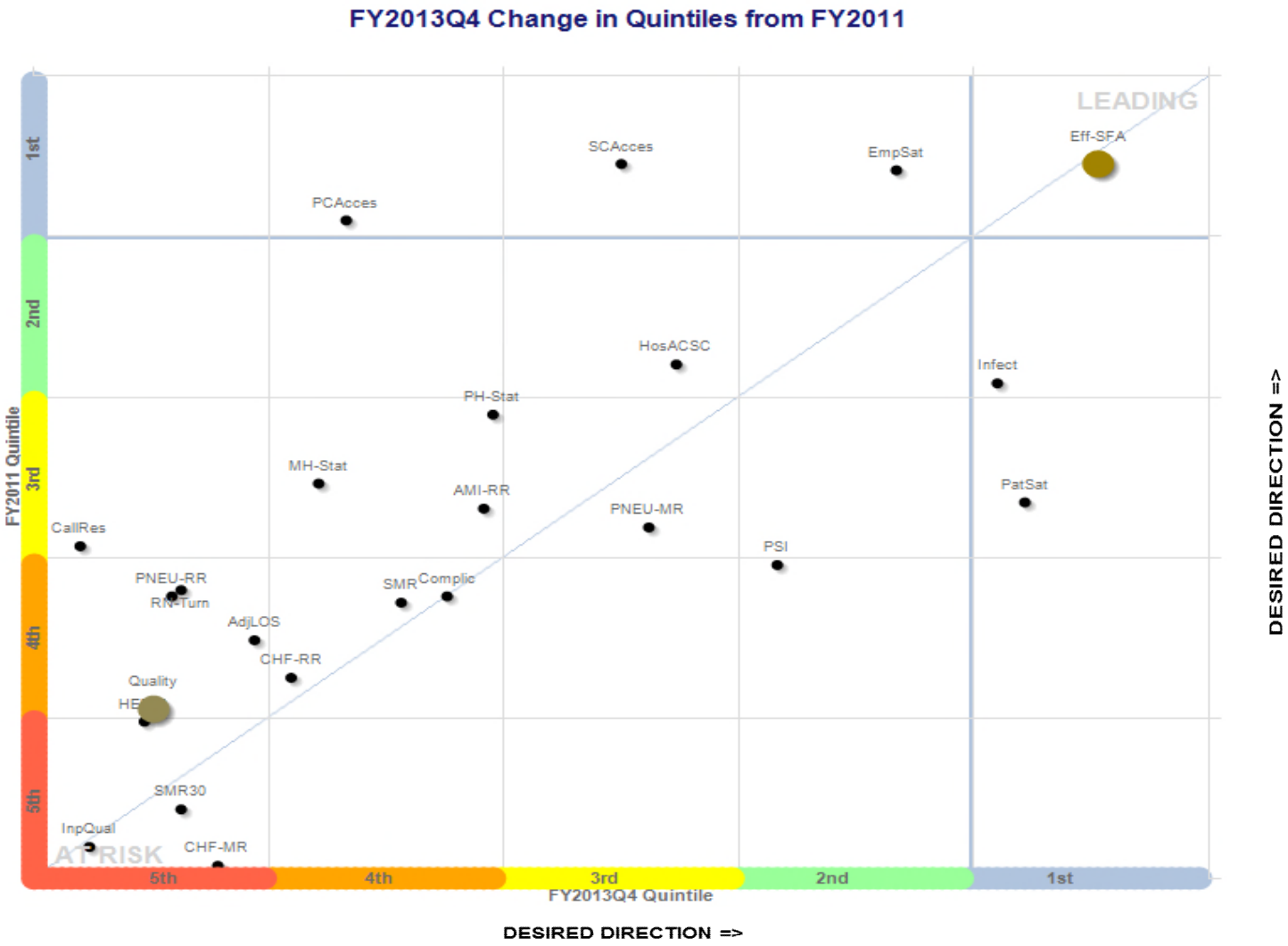
Strategic Analytics for Improvement and Learning (SAIL)[3]



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.

[3] 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

Acting VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: July 8, 2014

From: Acting Director, VA Southwest Health Care Network (10N18)

Subject: **CAP Review of the New Mexico VA Health Care System, Albuquerque, NM**

To: Director, Denver Office of Healthcare Inspections (54DV)

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

1. I concur with the attached facility responses and action plans detained in this draft report of the Combined Assessment Program Review of the New Mexico VA Health Care System, Albuquerque, NM.

2. If you have additional questions or concerns, please contact Robert Baum, VISN 18 Executive Officer to the Network Director, at (480) 397-2777.

(original signed by:)
Elizabeth Joyce Freeman
Acting Network Director

Interim Facility Director Comments

Department of Veterans Affairs **Memorandum**

Date: July 2, 2014

From: Interim Director, New Mexico VA Health Care System (501/00)

Subject: **CAP Review of the New Mexico VA Health Care System, Albuquerque, NM**

To: Director, VA Southwest Health Care Network (10N18)

1. I have reviewed and concur with the findings and recommendations in the draft report of the Office of Inspector General Combined Assessment Program Review conducted the week of June 2, 2014.

2. Corrective action plans have been established, with some being already implemented, and target completion dates have been set for the remaining items as detailed in the attached report.

(original signed by:)
James L. Robbins, MD
Interim Director

Comments to OIG's Report

The following Interim 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 Focused Professional Practice Evaluations for newly hired licensed independent practitioners are consistently initiated.

Concur

Target date for completion: August 2014

Facility response: A revised process for ensuring FPPE completion for newly hired licensed independent practitioners (LIP's) occurred in December 2013 with implementation of the process since January 2014. A master spreadsheet was developed to ensure and track compliance.

Recommendation 2. We recommended that processes be strengthened to ensure that continuing stay reviews are performed on at least 75 percent of patients in acute beds.

Concur

Target date for completion: November 2014

Facility response: Process for ongoing continuing stay reviews was reviewed and to ensure compliance of 75% of the reviews will be completed a staff plan is in place to address vacancies.

Recommendation 3. We recommended that processes be strengthened to ensure the blood/transfusions usage review process includes the results of proficiency testing and the results of peer reviews when transfusions did not meet criteria.

Concur

Target date for completion: December 2014

Facility response: The process for proficiency testing was reviewed and changes were made to improve the reporting process. Providers ordering transfusions will use the NMVAHCS template that includes indication for the transfusion. One hundred percent of blood transfusions orders will be reviewed for appropriateness (transfusion meets criteria) by the blood bank, results will be reported to the Tissue & Transfusion Committee. Orders for blood that have not used the template or where there is a mismatch between the indication and the patient's clinical status (e.g. indication is hemoglobin <7 but patient's lab result show hemoglobin of >7) will be referred to the

ordering clinical service for further review. The results of the clinical service review will be reported to the committee. Repetitive or unusually serious violations of transfusion criteria not met will be referred to the Chief of Staff for consideration for peer review as required by VHA Directive 2009-005 Transfusion Utilization Committee and Program Aggregate data on peer reviews related to transfusions will be reported back to the Tissue & Transfusion Committee for follow-up and action on system issues.

Recommendation 4. We recommended that processes be strengthened to ensure that actions taken when data analyses indicated problems or opportunities for improvement are consistently followed to resolution in outlier data, bar codes that were unable to scan, and blood transfusions.

Concur

Target date for completion: October 2014

Facility response: Action plans for outlier data, unable to scan bar codes and blood transfusion issues will be reported and tracked using a standardized format. The status of identified issues (e.g. current data) will be reported on a monthly basis to the Quality Board or the appropriate sub-committee until resolution.

Recommendation 5. We recommended that processes be strengthened to ensure that nurse call system alarms are functional and that compliance be monitored.

Concur

Target date for completion: November 2014

Facility response: The current nurse call system functionality is assessed on a continuous basis. Instances of call light failure will be reported daily during the Director's Morning Report, including actions taken to mitigate risk when a system is not functioning. Actions may include deployment of a temporary call system that has been purchased to serve as back-up to the primary system. The NMVAHCS has engaged the contracting office to expedite replacement of the nurse call system.

Recommendation 6. We recommended that processes be strengthened to ensure that clinicians complete and document National Institutes of Health stroke scales for each stroke patient and that compliance be monitored.

Concur

Target date for completion: December 31, 2014

The NIH stroke scale (or the reason why the scale is not appropriate) is to be documented by the Emergency Department nurse within 45 minutes for patients who present within 120 minutes of their onset of symptoms or within 24 hours if the patient presents >120 minutes after their onset of symptoms. If not completed by the ED nurse, documentation of the stroke scale by the attending or resident neurologist will be

considered acceptable. All stroke cases (100%) have been reviewed in 2014 by the Stroke Coordinator (report attached). Quarterly compliance ≥90% with completing the stroke scale will be achieved NLT December 2014.

Recommendation 7. We recommended that stroke guidelines be posted in the emergency department, on the critical care units, and on the medical and surgical units.

Concur

Target date for completion: July 30, 2014

Facility response: Stroke Guidelines/Algorithm are currently posted in the Emergency Department and MICU. Additional copies will be printed, laminated and posted on all critical care and medical/surgical units by July 30, 2014. To facilitate the posting of algorithm revisions, a table will be created listing the locations and the date posted.

Recommendation 8. We recommended that processes be strengthened to ensure that clinicians provide printed stroke education to patients upon discharge and that compliance be monitored.

Concur

Target date for completion: Completed

Compliance with providing the required patient education improved with the hiring of a stroke coordinator/educator. Stroke education compliance is monitored on 100% of cases and is reported monthly at the facility stroke meeting. In 2014 100% compliance was achieved in February and has been sustained for > 3 months.

Recommendation 9. We recommended that processes be strengthened to ensure that staff who are involved in assessing and treating stroke patients receive the training required by the facility and that compliance be monitored.

Concur

Target date for completion: December 31, 2014

Facility response: General stroke education will be added to all medical/surgical nurses educational profiles in Talent Management System (TMS) no later than July 31st 2014. Nursing will monitor completion rates by nursing unit and compliance of ≥90% will be achieved by the end of the calendar year.

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Endnotes

[a] References used for this topic included:
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