Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 14-02065-230

Combined Assessment Program Review of the Washington DC VA Medical Center Washington, DC

August 1, 2014

Washington, DC 20420

To Report Suspected Wrongdoing in VA Programs and Operations
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Glossary

CAP	Combined Assessment Program
CLC	community living center
ED	emergency department
EHR	electronic health record
EOC	environment of care
facility	Washington DC VA Medical Center
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

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 June 9, 2014.

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

- Acute Ischemic Stroke Care
- Community Living Center Resident Independence and Dignity

The facility's reported accomplishments were the Culinary Arts Program, which aims to provide state of the art professional kitchen training to veterans, and the Veterans and Community Health Sunday Magazine Radio Show, which provides round table discussions on health care issues.

Recommendations: We made recommendations in the following five activities:

Quality Management: Ensure that sufficient experienced senior physicians are members of the Peer Review Committee and that actions from peer reviews are consistently completed and reported to the committee. Consistently report Focused Professional Practice Evaluation results for newly hired licensed independent practitioners to the Medical Executive Committee. Implement an observation bed policy, and collect and analyze data related to observation bed use. Ensure Code Blue Committee code reviews include screening for clinical issues prior to the resuscitation event that may have contributed to the event. Require the Surgical Work Group to meet monthly. Analyze electronic health record (EHR) quality data at least quarterly, and ensure the review of EHR quality includes most services. Revise the quality control policy for scanning to include the handling of external source documents. Ensure the Transfusion Committee members from Medicine and Anesthesia Services consistently attend meetings.

Environment of Care: Require that Environment of Care Committee and Executive Committee of the Governing Body minutes reflect sufficient discussion of deficiencies, corrective actions taken, and tracking of actions to closure. Ensure that public restrooms are clean, that the surveillance monitoring system on the locked mental health unit is on at all times, and that the electronic patient monitoring system on the Community Living Center West unit is inspected and checks documented. Secure medications in the emergency department, on the dialysis unit, on the post-anesthesia care unit, and in the eye clinic.

Medication Management: Ensure the medication list provided to the patient/caregiver at discharge is reconciled with the dosage and frequency ordered.

Coordination of Care: Ensure progress notes in the EHR are individualized and accurate.

Magnetic Resonance Imaging Safety: Conduct contrast reaction and fire emergency drills in magnetic resonance imaging areas. Ensure that initial and secondary patient safety screenings are completed and that resolution of identified patient contraindications is documented in the EHR prior to the scan. Require that staff who may need to enter the magnetic resonance imaging area are designated as Level 1 ancillary staff and that all designated Level 1 and 2 staff receive annual level-specific safety training. Ensure appropriate physical barriers are in place to restrict access to Zones III and IV.

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 21–30, 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
- 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 2013 and FY 2014 through June 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 Washington, DC, VA Medical Center, Washington, DC,* Report No.12-00709-211, July 6, 2012). We made a repeat recommendation in EOC.

During this review, we presented crime awareness briefings for 369 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 189 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

Community Resource and Referral Center Culinary Arts Program

The Community Resource and Referral Center links veterans and their families to diverse community partners, resources, and programs aimed at ending homelessness and promoting community reintegration and independence. One of these programs is the facility's Culinary Arts Program, a licensed training opportunity for veterans interested in food preparation and handling. The program offers veterans access to a state of the art professional kitchen in which to practice their culinary skills and is unique to the facility.

Veterans and Community Health Sunday Magazine Radio Show

The facility has a Veterans and Community Health Sunday Magazine Radio Show, which offers listeners a weekly ½ hour dedicated health talk show. The radio segment is an opportunity to spotlight VA health care innovations, programs, and experiences. It is also a way to highlight the diverse cultures represented within the veteran population and facility staff.

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.	
X	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.	Six months of PRC meeting minutes reviewed: • Although PRC membership included staff physicians, it did not include the expected experienced senior physicians, such as the Chiefs of Primary Care and ED. • Of the eight actions expected to be completed, seven were not reported to the PRC.
X	Focused Professional Practice Evaluations for newly hired licensed independent practitioners were initiated and completed, and results were reported to the MEC.	Twelve profiles reviewed: • Results of five Focused Professional Practice Evaluations were not 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
X	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.	• The facility did not have an observation bed policy. • The facility did not gather observation bed use data.
	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 Code Blue Committee meeting minutes reviewed: • There was no evidence that code reviews included screening for clinical issues prior to 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. • Surgical deaths with identified problems or opportunities for improvement were reviewed. • Additional data elements were routinely reviewed.	• The Surgical Work Group only met 4 times over the past 6 months.
	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 EHR Committee meeting minutes reviewed: • EHR quality data was not analyzed quarterly. • The review of EHR quality did not include EHRs from Neurology, Outpatient, and Physical Medicine and Rehabilitation Services.
X	The policy for scanning non-VA care documents met selected requirements.	• The scanning policy did not include a quality control process for the handling of external source documents.

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 sets of Transfusion Committee meeting minutes reviewed: • Clinical representatives from Medicine and Anesthesia Services attended only two of four meetings.
	Overall, if significant issues were identified, actions were taken and evaluated for effectiveness.	
	Overall, senior managers were involved in performance improvement over the past 12 months.	
	Overall, the facility had a comprehensive, effective QM/performance improvement program over the past 12 months.	
	The facility met any additional elements required by VHA or local policy.	

Recommendations

1. We recommended that the Chief of Staff reconsider Peer Review Committee membership to ensure that sufficient experienced senior physicians are regular members.

2. We recommended that processes be strengthened to ensure that actions from peer reviews are consistently completed and reported to the Peer Review Committee.

3. We recommended that processes be strengthened to ensure that Focused Professional Practice Evaluation results for newly hired licensed independent practitioners are consistently reported to the Medical Executive Committee.

4. We recommended that a local observation bed policy be implemented and that data about observation bed use be collected and analyzed.

5. We recommended that processes be strengthened to ensure that Code Blue Committee code reviews include screening for clinical issues prior to the code that may have contributed to the occurrence of the code.

6. We recommended that the Surgical Work Group meet monthly.

7. We recommended that processes be strengthened to ensure that electronic health record quality data is analyzed at least quarterly and that the review of electronic health record quality includes most services.

8. We recommended that the quality control policy for scanning be revised to include the handling of external source documents.

9. We recommended that processes be strengthened to ensure that the Transfusion Committee members from Medicine and Anesthesia Services consistently attend meetings.

EOC

The purpose of this review was to determine whether the facility maintained a clean and safe health care environment in accordance with applicable requirements and whether the facility met selected requirements in SDS, the PACU, and the eye clinic.[b]

We inspected the locked MH, SDS, dialysis, medical intensive care, step down/progressive care, and neurology units; the PACU; one inpatient surgery unit; and the CLC West unit. We also inspected the ED and the women's health and eye clinics. Additionally, we reviewed relevant documents, conversed with key employees and managers, and reviewed 24 employee training records (11 SDS, 8 PACU, and 5 eye clinic). The table below shows the areas reviewed for this topic. The areas marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

NM	Areas Reviewed for General EOC	Findings
X	EOC Committee minutes reflected sufficient detail regarding identified deficiencies, corrective actions taken, and tracking of corrective actions to closure.	Eight months of EOC and 5 months of Executive Committee of the Governing Body meeting minutes reviewed: • Minutes did not reflect sufficient discussion of deficiencies, corrective actions taken, and tracking of 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.	• All six public restrooms inspected were in need of cleaning. • Although the surveillance monitoring system on the locked MH unit was functional, it was turned off. Five months of inspection documentation for the electronic patient monitoring system on the CLC West unit reviewed: • There was inconsistent documentation of required inspections. This was a repeat finding from the previous CAP review.
	Infection prevention requirements were met.	
X	Medication safety and security requirements were met.	• We found three unlocked and unattended supply/medication carts in the ED and on the dialysis unit.

NM	Areas Reviewed for General EOC (continued)	Findings
	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	
	Designated SDS and PACU employees received blood borne pathogens training during the past 12 months.	
NA	Designated SDS employees received medical laser safety training with the frequency required by local policy.	
	Fire safety requirements in SDS and on the PACU were met.	
	Environmental safety requirements in SDS and on the PACU were met.	
NA	SDS medical laser safety requirements were met.	
	Infection prevention requirements in SDS and on the PACU were met.	
X	Medication safety and security requirements in SDS and on the PACU were met.	• We found an unlocked and unattended supply/medication cart on the PACU.
	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.	
X	Medication safety and security requirements in the eye clinic were met.	• We found three unsecured medications on top of a treatment table in the eye clinic laser room. • We found an unsecured supply/medication cart in the eye clinic laser room.
	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.	

Recommendations

10. We recommended that processes be strengthened to ensure that Environment of Care Committee and Executive Committee of the Governing Body minutes reflect sufficient discussion of deficiencies, corrective actions taken, and tracking of actions to closure.

11. We recommended that processes be strengthened to ensure that public restrooms are clean and that compliance be monitored.

12. We recommended that processes be strengthened to ensure that the surveillance monitoring system on the locked mental health unit is on at all times and that compliance be monitored.

13. We recommended that processes be strengthened to ensure that the electronic patient monitoring system on the Community Living Center West unit is inspected and checks documented and that compliance be monitored.

14. We recommended that processes be strengthened to ensure that all medications in the emergency department, on the dialysis unit, on the post-anesthesia care unit, and in the eye clinic are secured 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 32 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
	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.	
X	Patients/caregivers were provided a written medication list at discharge, and the information was consistent with the dosage and frequency ordered.	• Four EHRs (13 percent) did not reflect that the medication list provided to the patient/caregiver at discharge had been reconciled 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

15. We recommended that processes be strengthened to ensure that the medication list provided to the patient/caregiver at discharge is reconciled with the dosage and frequency ordered and that compliance be monitored.

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 20 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 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
	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.	
X	The facility complied with any additional elements required by VHA or local policy.	• Five EHRs contained contradictory information about the patient in templated progress notes that were not individualized.

Recommendation

16. We recommended that processes be strengthened to ensure that progress notes in the electronic health record are individualized and accurate.

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 44 randomly selected patients who experienced stroke symptoms, and 15 employee training records, and we conversed with key employees. We also conducted onsite inspections of the ED, one critical care unit, and one acute inpatient unit. 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's stroke policy/plan/guideline addressed all required items.	
	Clinicians completed the National Institutes of Health stroke scale for each patient within the expected timeframe.	
	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.	
	Stroke guidelines were posted in all areas where patients may present with stroke symptoms.	
	Clinicians screened patients for difficulty swallowing prior to oral intake of food or medicine.	
	Clinicians provided printed stroke education to patients upon discharge.	
	The facility provided training to staff involved in 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.	

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 seven EHRs of residents (five residents receiving restorative nursing services and two residents not receiving restorative nursing services but candidates for services). We also observed 5 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. 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	
	Care planned/ordered assistive eating devices were provided to residents at meal times.	
	Required activities were performed during resident meal periods.	

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

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 24 employees (16 Level 1 ancillary staff and 8 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. 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 completed an MRI risk assessment, there were documented procedures for handling emergencies in MRI, and emergency drills were conducted in the MRI area.	• Contrast reaction and fire emergency drills were not conducted in the MRI areas.
X	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.	• Seventeen EHRs (49 percent) did not contain initial patient safety screenings. • Twenty EHRs (57 percent) did not contain secondary patient safety screenings prior to MRI.
X	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.	• Three of the 15 secondary screening forms did not contain documentation that all identified potential contraindications were addressed prior to MRI.
X	Level 1 ancillary staff and Level 2 MRI personnel were designated and received level-specific annual MRI safety training.	• None of the Level 1 ancillary staff received level-specific annual MRI safety training. • The facility did not designate any nursing personnel as Level 1 ancillary staff even though nursing staff assist in transporting and monitoring critically ill patients during an MRI. • Two Level 2 MRI personnel did not receive level-specific annual MRI safety training.
X	Signage and barriers were in place to prevent unauthorized or accidental access to Zones III and IV.	• Zones III and IV were not adequately protected to prohibit unauthorized access.
	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.	

NM	Areas Reviewed (continued)	Findings
	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.	

Recommendations

17. We recommended that processes be strengthened to ensure that contrast reaction and fire emergency drills are conducted in magnetic resonance imaging and that compliance be monitored.

18. We recommended that processes be strengthened to ensure that initial patient safety screenings are conducted and that compliance be monitored.

19. We recommended that processes be strengthened to ensure that secondary patient safety screenings are completed prior to magnetic resonance imaging and documented in the electronic health record and that compliance be monitored.

20. We recommended that processes be strengthened to ensure that radiologists and/or Level 2 magnetic resonance imaging personnel document resolution in the patients' electronic health records of all identified magnetic resonance imaging contraindications prior to the scan and that compliance be monitored.

21. We recommended that all staff who may need to enter the magnetic resonance imaging area be designated as Level 1 ancillary staff.

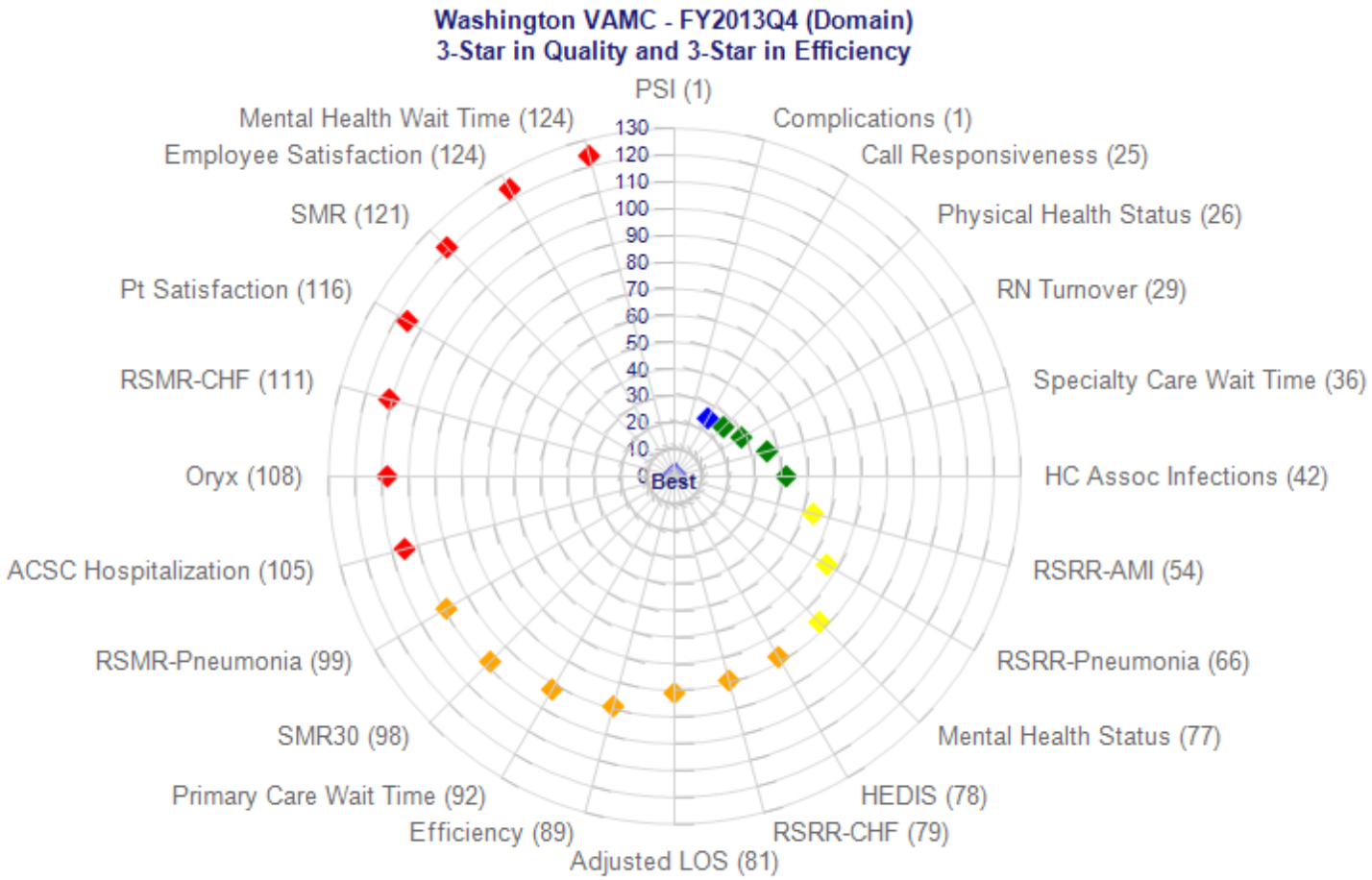
22. We recommended that processes be strengthened to ensure that all designated Level 1 and 2 staff receive annual level-specific magnetic resonance imaging safety training and that compliance be monitored.

23. We recommended that appropriate physical barriers be in place to restrict access to magnetic resonance imaging Zones III and IV.

Facility Profile (Washington, DC/688) FY 2014 through June 2014[1]	
Type of Organization	Tertiary
Complexity Level	1b-High complexity
Affiliated/Non-Affiliated	Affiliated
Total Medical Care Budget in Millions	$462.9
Number of:	
• **Unique Patients**	57,051
• **Outpatient Visits**	473,915
• **Unique Employees**[2]	2,110
Type and Number of Operating Beds:	
• **Hospital**	175
• **CLC**	120
• **MH**	NA
Average Daily Census (May 2014):	
• **Hospital**	133
• **CLC**	99
• **MH**	NA
Number of Community Based Outpatient Clinics	5
Location(s)/Station Number(s)	Fort Belvoir/688GA SE Washington/688GB Landover/Greenbelt/688GC Charlotte Hall/688GD Southern Prince George's/688GE
VISN Number	5

[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.

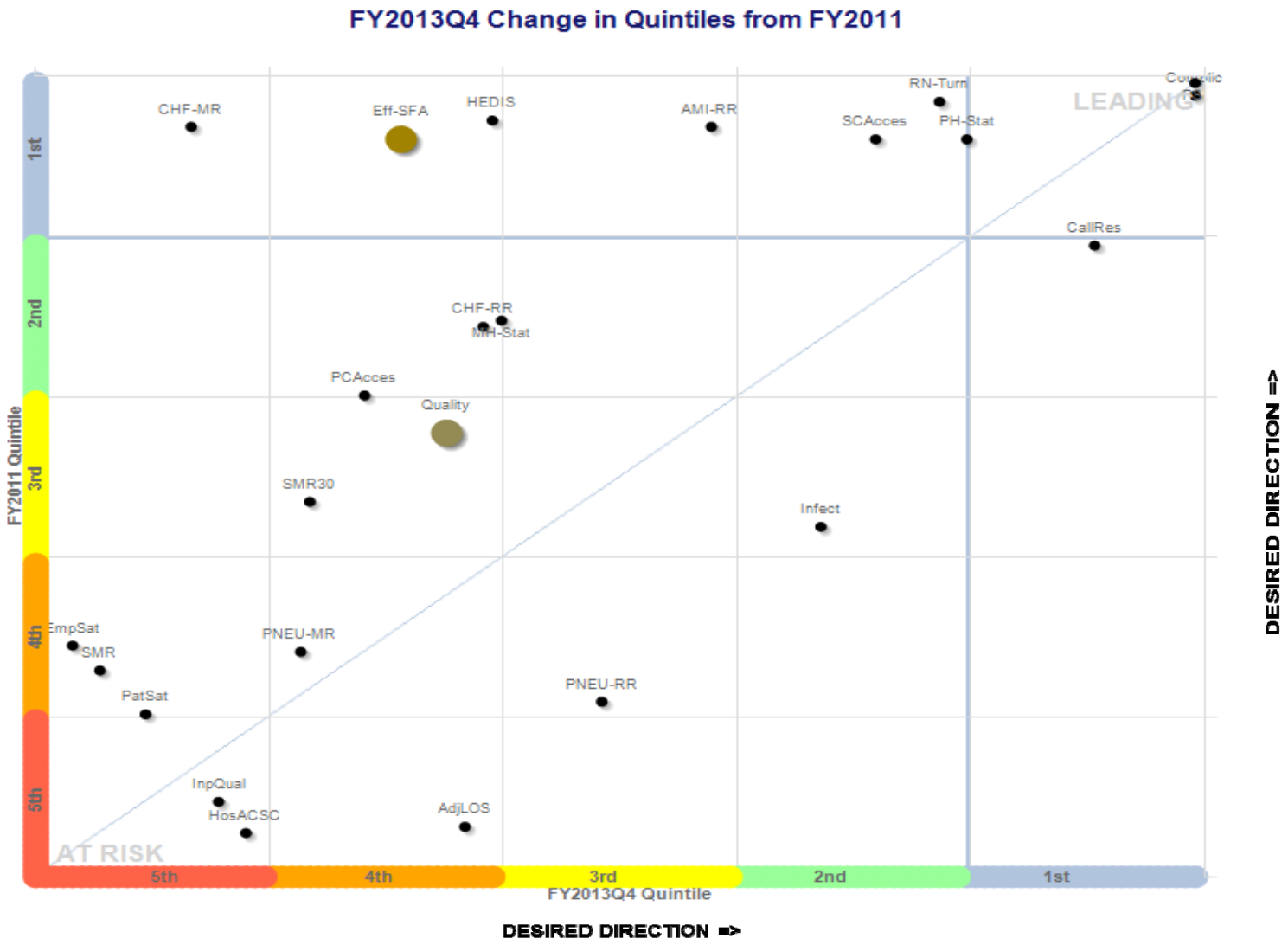
Strategic Analytics for Improvement and Learning (SAIL)[3]



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

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: July 1, 2014

From: Director, VA Capitol Health Care Network (10N5)

Subject: **CAP Review of the Washington DC VA Medical Center, Washington, DC**

To: Director, Bay Pines Office of Healthcare Inspections (54SP)

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

1. I have reviewed the comments provided by the Medical Center Director, DC VA Medical Center and concur with the responses and actions to the recommendations outlined in the report.

2. Should you require any additional information, please contact Jeffrey Lee, Quality Management Officer, VA Capitol Health Care Network, VISN 5 at 410-691-7816.

(original signed by:)
Fernando O. Rivera, FACHE

Facility Director Comments

Department of Veterans Affairs **Memorandum**

Date: July 1, 2014

From: Director, Washington DC VA Medical Center (688/00)

Subject: **CAP Review of the Washington DC VA Medical Center, Washington, DC**

To: Director, VA Capitol Health Care Network (10N5)

1. Thank you for the opportunity to review the draft report and I concur with the OIG recommendations.

2. Our corrective actions have been established with planned completion dates as detailed in the attached report.

3. If you have any questions please contact Geraldlene Adams, BSN, MBA, Director of Quality Management at 202-745-8564.

(original signed by:)
Brian A. Hawkins, MHA
Medical Center Director

Comments to OIG's Report

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

OIG Recommendations

Recommendation 1. We recommended that the Chief of Staff reconsider Peer Review Committee membership to ensure that sufficient experienced senior physicians are regular members.

Concur

Target date for completion: June 30, 2014

Facility response: VHA Directive 2010-025, attachment D section 1 which outlines the required composition and qualifications of the Peer Review Committee (PRC), does not specify which physicians must be members of the PRC. The DC VAMC PRC is comprised of a multi-disciplinary team of experienced senior physicians from Medicine Service, Surgery Service, Behavioral Health, Nursing, and Radiology along with Quality Management at each meeting. When appropriate, ad-hoc members are invited and attend and vote on the level recommendations.

The reviewer suggested that the Chief of the Emergency Department (ED) and Primary Care (PC) be added as regular members to the committee. Both of these sections fall under Medicine Service. This recommendation was discussed in the June 17, 2014, PRC meeting and it was determined that DC VAMC would continue to request ED and PC representation on an ad-hoc basis, because patient appointment scheduling for Chiefs of PC and ED limits their availability. The Risk Manager will extend the invitation based on the appropriateness of the cases being reviewed.

Recommendation 2. We recommended that processes be strengthened to ensure that actions from peer reviews are consistently completed and reported to the Peer Review Committee.

Concur

Target date for completion: September 30, 2014

Facility response: The Risk Manager will send out reminders to Service Chiefs for completion of actions with due dates. The Chief of Staff will reinforce all open actions in the weekly Bed Service Chief Meeting and report compliance in the Medical Executive Committee.

Recommendation 3. We recommended that processes be strengthened to ensure that Focused Professional Practice Evaluation results for newly hired licensed independent practitioners are consistently reported to the Medical Executive Committee.

Concur

Target date for completion: September 30, 2014

Facility response: FPPE reporting is now completed at the beginning of each MEC meeting. The tracking and scheduling of the required reports is conducted by the Chief of Staff office. Compliance will be monitored by the Quality Council monthly for 4 consecutive months of 100 percent compliance beginning June, 2014.

Recommendation 4. We recommended that a local observation bed policy be implemented and that data about observation bed use be collected and analyzed.

Concur

Target date for completion: September 30, 2014

Facility response: The draft observation policy was available at the time of the review and is on the Medical Executive Committee's July 8, 2014 agenda for approval. Monitoring of the observation patients had begun May 1, 2014, and is currently at 98 percent reviewed.

Recommendation 5. We recommended that processes be strengthened to ensure that Code Blue Committee 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 30, 2014

Facility response: The Code Blue monitoring tool was revised to include documentation of screening for preexisting clinical issues prior to the code. Additionally, all code blue reviewers were appraised of the facility adaption of OIG recommendations to include Rapid Response calls (if any) and review of the patient's condition at least 48 hours prior to the code event as newly added steps to DC VAMC's current process.

Recommendation 6. We recommended that the Surgical Work Group meet monthly.

Concur

Target date for completion: September 30, 2014

Facility response: At the Facility Surgical Work Group meeting on June 23, 2014, the meeting schedule for FY14-15 was discussed and revised. To improve compliance with attendance, future meeting dates have been scheduled to occur on the Monday of the

third week of each month. The need for maximum attendance by all committee members (or designated representative) was also discussed and encouraged.

Recommendation 7. We recommended that processes be strengthened to ensure that electronic health record quality data is analyzed at least quarterly and that the review of electronic health record quality includes most services.

Concur

Target date for completion: September 30, 2014

Facility response: The MRC committee will report quarterly the quality reviews conducted by each service representative to the MEC. A schedule of service reports for the year will be developed and issued at the July 2, 2014 meeting.

Recommendation 8. We recommended that the quality control policy for scanning be revised to include the handling of external source documents.

Concur

Target date for completion: July 30, 2014

Facility response: The Chief of Health Information Management Service (HIMS) has made the necessary changes to the scanning policy and will bring the revised policy to the July 2, 2104 MRC meeting. Once approved at the MRC, it will go to Medical Executive Committee. A quality audit will be conducted on all scanned documents and reported to the MRC monthly, to begin on July 1, 2014.

Recommendation 9. We recommended that processes be strengthened to ensure that the Transfusion Committee members from Medicine and Anesthesia Services consistently attend meetings.

Concur

Target date for completion: September 30, 2014

Facility response: The Transfusion Committee membership is comprised of two physicians from Medicine Service: one from general Medicine and Hematology. There is consistent attendance for Medicine because one is always in attendance, if not both. Anesthesia Service has been under a critical shortage, and has been excused by the committee chairperson until positions are filled by July 30, 2014. Once the positions are filled, Anesthesia Service will be required to consistently attend Transfusion Committee meetings.

Recommendation 10. We recommended that processes be strengthened to ensure that Environment of Care Committee and Executive Committee of the Governing Body minutes reflect sufficient discussion of deficiencies, corrective actions taken, and tracking of actions to closure.

Concur

Target date for completion: September 30, 2014

Facility response: The EOC Committee Chair will ensure that the deficiencies are discussed to include corrective actions and preventative measures. The EOC Committee Chair will ensure that sufficient discussion for each identified deficiency is reflected in the minutes, to include tracking and trending until closure, prior to accepting/signing official monthly minutes. The same detail will be also be followed monthly by the Executive Committee of the Governing Body and Chair.

Recommendation 11. We recommended that processes be strengthened to ensure that public restrooms are clean and that compliance be monitored.

Concur

Target date for completion: September 30, 2014

Facility response: The facilities' public restrooms are currently in different stages of renovation. The opening of additional public restrooms for the first floor occurred on June 16, 2014. The Atrium restroom renovation will begin on July 15, 2014. To meet the demands of the restroom usage, the environmental management systems (EMS) staff will increase cleaning rounds to hourly with a checklist for supervisor review. Audits will be reported to the EOC committee on a monthly basis for compliance until end of fiscal year 2014.

Recommendation 12. We recommended that processes be strengthened to ensure that the surveillance monitoring system on the locked mental health unit is on at all times and that compliance be monitored.

Concur

Target date for completion: August 30, 2014

Facility response: A new surveillance system is being installed in the locked mental health unit with a target completion date of August 2014. During the OIG survey, an older monitor was identified to have a power malfunction that resulted in automatic power off. The equipment has since been evaluated and a permanent replacement will be obtained as part of the new surveillance system. The identified faulty equipment has been temporarily replaced by a fully operational desk top monitor to ensure continued surveillance by staff and police services.

Recommendation 13. We recommended that processes be strengthened to ensure that the electronic patient monitoring system on the Community Living Center West unit is inspected and checks documented and that compliance be monitored.

Concur

Target date for completion: September 30, 2014

Facility response: Community Living Center nursing leadership staff has identified the inspection of the electronic patient monitoring system followed by documentation of checks as a priority issue. Review of the inspection process and documentation requirements was performed by the Nurse Managers during staff meetings and face-to-face small group discussion in June 2014. Compliance with daily documentation of shift inspections will be completed by the Nurse Leader. Overall compliance will be monitored by the CLC Nursing Supervisor via a monthly review of the checklist and reported to the CLC Administration Committee.

Recommendation 14. We recommended that processes be strengthened to ensure that all medications in the emergency department, on the dialysis unit, on the post-anesthesia care unit, and in the eye clinic are secured and that compliance be monitored.

Concur

Target date for completion: September 30, 2014

Facility response: Monitoring of medication security has been increased to include the Nurse Managers inspecting the recommended areas on a daily basis. Additionally, QM, Pharmacy and Patient Safety staff will also perform random audits in each section for a total of 40 observations per month.

Recommendation 15. We recommended that processes be strengthened to ensure that the medication list provided to the patient/caregiver at discharge is reconciled with the dosage and frequency ordered and that compliance be monitored.

Concur

Target date for completion: September 30, 2014

Facility response: Clinical Pharmacy Specialists assigned to the inpatient provider teams will serve as a resource to the providers and reinforce the requirement to ensure medication reconciliation has occurred prior to patient discharge. Additionally, a Process Action Team composed of representatives from Clinical Informatics, Pharmacy, and Medical Staff has been formed with the task to review the medication reconciliation and ordering process involved at patient discharge and to identify any system breakdowns and/or deviation(s) in practice. This action item will be tracked through the monthly Medical Records Committee meetings. Compliance with the current process and/or any implemented changes will be monitored via records audit (30 per month)

with results trended and reported to the Medical Records Committee. The target date for completion is September 30, 2014 with follow-up including monthly records audits for six months and then intermittent monitoring.

Recommendation 16. We recommended that processes be strengthened to ensure that progress notes in the electronic health record are individualized and accurate.

Concur

Target date for completion: September 30, 2014

Facility response: The incorrect information found in the electronic medical record reviewed was related to the text box being inappropriately checked that instructions were given to the patient when they were not capable of understanding discharge instructions. To prevent this error, Nursing Informatics added a required check box that accurately reflects who was provided discharge instructions and the level of understanding. This function was added on June 24, 2014 and the Nursing PI committee will monitor 50 discharge records per month for compliance for Q4, FY14. Education of the staff will be completed by June 30, 2014 on the changes and findings.

Recommendation 17. We recommended that processes be strengthened to ensure that contrast reaction and fire emergency drills are conducted in magnetic resonance imaging and that compliance be monitored.

Concur

Target date for completion: June 24, 2014

Facility response: The Fire emergency drill was completed in MRI on June 24, 2014 and contrast reaction drill was completed June 25, 2014. Subsequent drills will occur on an annual basis in accordance with DC VAMC policy.

Recommendation 18. We recommended that processes be strengthened to ensure that initial patient safety screenings are conducted and that compliance be monitored.

Concur

Target date for completion: September 30, 2014

Facility response: A force function has been added in CPRS to prevent placement of an MRI order by the physician until the initial safety screening has been completed. This function was added on June 24, 2014. Follow-up on monitoring for compliance to identify overrides and any other issues will be completed over the next 30 days by the Department of Radiology's Administrator and Technician Supervisor.

Recommendation 19. We recommended that processes be strengthened to ensure that secondary patient safety screenings are completed prior to magnetic resonance imaging and documented in the electronic health record and that compliance be monitored.

Concur

Target date for completion: September 30, 2014

Facility response: The MRI staff collaborated with Informatics staff to change the secondary screening template to a required document with no overrides. The MRI staff and physicians have been educated on the screening use and functions and compliance will be monitored by patient record review. Review will be 10 percent of the MRIs performed in a month compliance rate and reported to patient safety committee for 3 months.

Recommendation 20. We recommended that processes be strengthened to ensure that radiologists and/or Level 2 magnetic resonance imaging personnel document resolution in the patients' electronic health records of all identified magnetic resonance imaging contraindications prior to the scan and that compliance be monitored.

Concur

Target date for completion: September 30, 2014

Facility response: The Patient Safety Screening Form was modified to allow for documentation of review of all contraindications identified prior to MRI procedure. All MRI Technologist and Radiologists have been informed and educated about this revision. Older versions of the form have been replaced with the newer version for immediate use. Compliance with this process improvement issue will be measured using the records review method and reported and discussed at the MRI Safety Committee meeting.

Recommendation 21. We recommended that all staff who may need to enter the magnetic resonance imaging area be designated as Level 1 ancillary staff.

Concur

Target date for completion: July 30, 2014

Facility response: After an assessment of staff at all levels who may need to enter the MRI outer area, the following staff will be designated as Level 1 Ancillary staff: all Respiratory Therapists, Anesthesia Staff, and RNs assigned to the Emergency Department, Medical ICU, and Surgical ICU. An MRI Safety training package has been uploaded into the Talent Management System and assigned to all identified clinical staff with a target training completion date of July 30, 2014. The goal of this training is to educate all clinical staff on MRI safety.

Recommendation 22. We recommended that processes be strengthened to ensure that all designated Level 1 and Level 2 staff receive annual level-specific magnetic resonance imaging safety training and that compliance be monitored.

Concur

Target date for completion: September 30, 2014

Facility response: Completion of the annual Level 1 MRI Safety Training will be accomplished by the addition of the Level 1 TMS supported training to the annual training requirement for identified staff (target completion date is (July 30, 2014). Completion of Level 2 MRI Safety Training for MRI staff was accomplished in a timely manner but not verified due lack of documented participation. A correction was achieved via re-training the staff of level 2 training on June 16, 2014, with the attendance documented using a sign-in sheet.

Recommendation 23. We recommended that appropriate physical barriers be in place to restrict access to magnetic resonance imaging Zones III and IV.

Concur

Target date for completion: July 30, 2014

Facility response: The purchase of badge access locks to the MRI Zone areas was approved and they are currently being put in place. The pre-wiring work is completed with the installation of the hardware to be completed by July 30, 2014. The issuance of badges to staff and training will follow final installation and testing.

OIG Contact and Staff Acknowledgments

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

Endnotes

[a] References used for this topic included:
- VHA Directive 2009-043, *Quality Management System*, September 11, 2009.
- VHA Handbook 1050.01, *VHA National Patient Safety Improvement Handbook*, March 4, 2011.
- VHA Directive 2010-017, *Prevention of Retained Surgical Items*, April 12, 2010.
- VHA Directive 2010-025, *Peer Review for Quality Management*, June 3, 2010.
- VHA Directive 2010-011, *Standards for Emergency Departments, Urgent Care Clinics, and Facility Observation Beds*, March 4, 2010.
- VHA Directive 2009-064, *Recording Observation Patients*, November 30, 2009.
- VHA Handbook 1100.19, *Credentialing and Privileging*, October 15, 2012.
- VHA Directive 2008-063, *Oversight and Monitoring of Cardiopulmonary Resuscitative Events and Facility Cardiopulmonary Resuscitation Committees*, October 17, 2008.
- VHA Handbook 1907.01, *Health Information Management and Health Records*, September 19, 2012.
- VHA Directive 6300, *Records Management*, July 10, 2012.
- VHA Directive 2009-005, *Transfusion Utilization Committee and Program*, February 9, 2009.
- VHA Handbook 1106.01, *Pathology and Laboratory Medicine Service Procedures*, October 6, 2008.

[b] References used for this topic included:
- VHA Directive 2011-007, *Required Hand Hygiene Practices*, February 16, 2011.
- VHA Handbook 1121.01, *VHA Eye Care*, March 10, 2011.
- VA National Center for Patient Safety, "Multi-Dose Pen Injectors," Patient Safety Alert 13-04, January 17, 2013.
- "Adenovirus-Associated Epidemic Keratoconjunctivitis Outbreaks –Four States, 2008–2010," Centers for Disease Control and Prevention Morbidity and Mortality Weekly Report, August 16, 2013.
- Various requirements of The Joint Commission, the Occupational Safety and Health Administration, the American National Standards Institute/Advancing Safety in Medical Technology, the Centers for Disease Control and Prevention, the International Association of Healthcare Central Service Materiel Management ,the National Fire Protection Association, the Health Insurance Portability and Accountability Act, Underwriters Laboratories.

[c] References used for this topic included:
- VHA Handbook 1108.06, *Inpatient Pharmacy Services*, June 27, 2006.
- VHA Handbook 1108.05, *Outpatient Pharmacy Services*, May 30, 2006.
- VHA Directive 2011-012, *Medication Reconciliation*, March 9, 2011.
- VHA Handbook 1907.01, *Health Information Management and Health Records*, September 19, 2012.
- Manufacturer's instructions for Cipro® and Levaquin®.
- Various requirements of The Joint Commission.

[d] References used for this topic included:
- VHA Handbook 1120.04, *Veterans Health Education and Information Core Program Requirements*, July 29, 2009.
- VHA Handbook 1907.01, *Health Information Management and Health Records*, September 19, 2012.
- The Joint Commission, *Comprehensive Accreditation Manual for Hospitals*, July 2013.

[e] The references used for this topic were:
- VHA Directive 2011-038, Treatment of Acute Ischemic Stroke, November 2, 2011.
- Guidelines for the Early Management of Patients with Acute Ischemic Stroke (AHA/ASA Guidelines), January 31, 2013.

[f] References used for this topic included:
- VHA Handbook 1142.01, *Criteria and Standards for VA Community Living Centers (CLC)*, August 13, 2008.
- VHA Handbook 1142.03, *Requirements for Use of the Resident Assessment Instrument (RAI) Minimum Data Set (MDS)*, January 4, 2013.
- Centers for Medicare and Medicaid Services, *Long-Term Care Facility Resident Assessment Instrument User's Manual*, Version 3.0, May 2013.
- VHA Manual M-2, Part VIII, Chapter 1, *Physical Medicine and Rehabilitation Service*, October 7, 1992.
- Various requirements of The Joint Commission.

[g] References used for this topic included:

- VHA Handbook 1105.05, *Magnetic Resonance Imaging Safety*, July 19, 2012.
- Emanuel Kanal, MD, et al., "ACR Guidance Document on MR Safe Practices: 2013," *Journal of Magnetic Resonance Imaging*, Vol. 37, No. 3, January 23, 2013, pp. 501–530.
- The Joint Commission, "Preventing accidents and injuries in the MRI suite," Sentinel Event Alert, Issue 38, February 14, 2008.
- VA National Center for Patient Safety, "MR Hazard Summary," http://www.patientsafety.va.gov/professionals/hazards/mr.asp.
- VA Radiology, "Online Guide," http://vaww1.va.gov/RADIOLOGY/OnLine_Guide.asp, updated October 4, 2011.