Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 14-02072-283

Combined Assessment Program Review of the VA Southern Oregon Rehabilitation Center and Clinics White City, Oregon

September 11, 2014

Washington, DC 20420

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

Glossary

CAP	Combined Assessment Program
CS	controlled substances
EHR	electronic health record
EOC	environment of care
facility	VA Southern Oregon Rehabilitation Center and Clinics
FY	fiscal year
MEC	Medical Executive Committee
MH	mental health
MM	medication management
NA	not applicable
NM	not met
OIG	Office of Inspector General
PACU	post-anesthesia care unit
PRC	Peer Review Committee
QM	quality management
RRTP	residential rehabilitation treatment program
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, and to provide crime awareness briefings. We conducted the review the week of July 21, 2014.

Review Results: The review covered eight activities. We made no recommendations in the following activity:

- Management of Workplace Violence

The facility's reported accomplishment was the development of the Veterans Day Respite program, which provides socialization to and assists with community integration of veterans living in rural areas and provides support for their caregivers.

Recommendations: We made recommendations in the following seven activities:

Quality Management: Implement a quality control policy for scanning that includes all required elements.

Environment of Care: Ensure infection prevention materials are available for eye clinic patients, visitors, and family members. Store dirty items in the eye clinic away from patient care areas. Reprocess ophthalmology pachymetry probes in accordance with manufacturer's instructions.

Medication Management – Controlled Substances Inspection Program: Amend facility policy to include that Controlled Substances Coordinators must be free from conflicts of interest, that controlled substances inspectors must be appointed in writing, and that annual updates for controlled substances inspectors include problematic issues identified through external survey findings and other quality control measures. Develop instructions for inspections of automated dispensing machines.

Continuity of Care: Consistently scan medical information from non-VA hospitalizations into electronic health records.

Management of Test Results: Notify licensed independent practitioners of critical laboratory test results/values within the expected timeframe, and document notification in the electronic health records. Notify patients of normal test results/values within the expected timeframe, and document notification in the electronic health records.

Suicide Prevention Program: Ensure that safety plans contain documentation of assessment of available lethal means and ways to keep the environment safe and that patients and/or their families receive a copy of the safety plan.

Mental Health Residential Rehabilitation Treatment Program: Ensure written agreements acknowledging resident responsibility for medication security are in place in the domiciliary and the Domiciliary Care for Homeless Veterans Program.

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 21–27, for the full text of the Directors' comments.) We consider recommendations 2 and 3 closed. We will follow up on the planned actions for the open recommendations until they are completed.

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

Objectives and Scope

Objectives

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

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

Scope

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

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

- QM
- EOC
- MM – CS Inspection Program
- Continuity of Care
- Management of Test Results
- Suicide Prevention Program
- Management of Workplace Violence
- MH RRTP

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 July 24, 2014, and was done in accordance with OIG standard operating procedures for CAP reviews. We also asked the facility to provide the status on the recommendations we made in our previous CAP report (*Combined Assessment Program Review of the VA Southern Oregon Rehabilitation Center and Clinics, White City, Oregon,* Report No. 12-02601-07, October 17, 2012).

During this review, we presented crime awareness briefings for 172 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 282 responded. We shared summarized results with the acting facility Director.

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

Reported Accomplishment

Veterans Day Respite Program

The facility has expanded services in the Grants Pass, OR, area with the implementation of an adult day program. The Veterans Day Respite program provides socialization to and assists with community integration of veterans living in rural areas who are currently enrolled in VA care, may be at risk of nursing home placement, or are homebound or socially isolated. VA staff provide an array of activities and supportive services to the veteran and his or her family. The 5-hour a day program is held in rural community locations, such as the American Legion hall. Recreational programming is designed to improve or maintain physical and mental functioning, increase socialization, and develop leisure skills. Veterans receive snacks and one daily meal along with certified nursing assistance with activities of daily living. The program serves as respite for the veteran's caregiver, who is supported through inclusive programming and a monthly caregiver support group.

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

NM	Areas Reviewed (continued)	Findings
NA	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.	
NA	Staff performed continuing stay reviews on at least 75 percent of patients in acute beds.	
NA	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.	
NA	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.	
NA	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.	
X	The policy for scanning non-VA care documents met selected requirements.	• The facility lacked a scanning policy.

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

Recommendation

1. We recommended that the facility implement a quality control policy for scanning that includes all required elements.

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 primary care clinic, dental clinic, infirmary, and eye clinic. Additionally, we reviewed relevant documents, and conversed with key employees and managers. 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.	
	Environmental safety requirements were met.	
	Infection prevention requirements were met.	
	Medication safety and security requirements were met.	
	Auditory privacy requirements were met.	
	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.	
	Areas Reviewed for SDS and the PACU	
NA	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	Fire safety requirements in SDS and on the PACU were met.	
NA	Environmental safety requirements in SDS and on the PACU were met.	
NA	SDS medical laser safety requirements were met.	

NM	Areas Reviewed for SDS and the PACU (continued)	Findings
NA	Infection prevention requirements in SDS and on the PACU were met.	
NA	Medication safety and security requirements in SDS and on the PACU were met.	
NA	Auditory privacy requirements in SDS and on the PACU were met.	
NA	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.	
	Areas Reviewed for Eye Clinic	
NA	Designated eye clinic employees received laser safety training with the frequency required by local policy.	
	Environmental safety requirements in the eye clinic were met.	
X	Infection prevention requirements in the eye clinic were met.	• The eye clinic had no infection prevention educational materials for patients, visitors, or family members. • Dirty items were stored in a patient care area. • Employees did not reprocess ophthalmology pachymetry probes according to manufacturer's instructions.
	Medication safety and security requirements in the eye clinic were met.	
NA	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

2. We recommended that processes be strengthened to ensure that infection prevention educational materials are available for eye clinic patients, visitors, and family members.

3. We recommended that processes be strengthened to ensure that dirty items in the eye clinic are not stored in patient care areas and that compliance be monitored.

4. We recommended that processes be strengthened to ensure that employees reprocess ophthalmology pachymetry probes in accordance with manufacturer's instructions and that compliance be monitored.

MM – CS Inspection Program

The purpose of this review was to determine whether the facility complied with requirements related to CS security and inspections.[c]

We reviewed relevant documents and conversed with key employees. We also reviewed the training files of the CS Coordinator, the alternate CS Coordinator, and six CS inspectors and inspection documentation from two CS areas and the pharmacy. 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	Facility policy was consistent with VHA requirements.	Facility CS inspection policy reviewed: • Facility policy did not address that CS Coordinators should not have a connection with any component of the CS program, that CS inspectors must be appointed in writing, and that annual updates for CS inspectors should include problematic issues identified through external survey findings and other quality control measures.
	VA police conducted annual physical security surveys of the pharmacy, and any identified deficiencies were corrected.	
X	Instructions for inspecting automated dispensing machines were documented, included all required elements, and were followed.	• Instructions for inspecting automated dispensing machines had not been developed.
	Monthly CS inspection findings summaries and quarterly trend reports were provided to the facility Director.	
	CS Coordinator position description(s) or functional statement(s) included duties, and CS Coordinator(s) completed required certification and were free from conflicts of interest.	
	CS Inspectors were appointed in writing, were limited to 3-year terms, completed required certification and training, and were free from conflicts of interest.	
	Non-pharmacy areas with CS were inspected in accordance with VHA requirements, and inspections included all required elements.	
	Pharmacy CS Inspections were conducted in accordance with VHA requirements and included all required elements.	
	The facility complied with any additional elements required by VHA or local policy.	

Recommendations

5. We recommended that facility policy be amended to include that Controlled Substances Coordinators must be free from conflicts of interest, that controlled substances inspectors must be appointed in writing, and that annual updates for controlled substances inspectors include problematic issues identified through external survey findings and other quality control measures.

6. We recommended that the facility develop instructions for inspections of automated dispensing machines.

Continuity of Care

The purpose of this review was to evaluate whether clinical information from patients' community hospitalizations at VA expense was scanned and available to facility providers and whether providers documented acknowledgement of it.[d] Such information is essential to coordination of care and optimal patient outcomes.

We reviewed relevant documents and the EHRs of 30 patients who had been hospitalized at VA expense in the local community from February 1, 2013, through February 1, 2014. The table below shows the areas reviewed for this topic. The area marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

NM	Areas Reviewed	Findings
X	Clinical information was consistently available to the primary care team for the clinic visit subsequent to the non-VA hospitalization.	• Medical information from 23 patients' non-VA hospitalizations (77 percent) was not scanned into the EHRs.
	Members of the patients' primary care teams documented that they were aware of the patients' non-VA hospitalization.	
	The facility complied with any additional elements required by VHA or local policy.	

Recommendation

7. We recommended that processes be strengthened to ensure that the medical information from non-VA hospitalizations is consistently scanned into the electronic health records and that compliance be monitored.

Management of Test Results

The purpose of this review was to evaluate whether the facility complied with selected requirements for managing test results.[e]

We reviewed relevant policies and procedures and the EHRs of 12 patients who had critical laboratory or abnormal cytology test results/values in FY 2014 (10 for laboratory and 2 for cytology). In addition, we reviewed the EHRs of 30 patients who had normal laboratory, radiology, or Pap smear results/values. We also conversed with key employees. The table below shows the areas reviewed for this topic. The areas marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

NM	Areas Reviewed	Findings
	The facility had a written policy or guideline that addressed the management of critical/ abnormal test results/values, and compliance was monitored.	
X	Providers were notified of critical/abnormal test results/values by appropriate staff within the expected timeframe.	• Four of the 10 critical laboratory results/values were reported to non-licensed independent practitioners. • Four of the 10 EHRs of patients with critical laboratory results/values did not contain documentation of notification to a licensed independent practitioner within the facility's expected timeframe of 30 minutes.
	Patients were notified of critical/abnormal test results/values within the expected timeframe and by the approved method of communication.	
	Follow-up actions were taken in response to critical/abnormal test results/values.	
X	Patients were notified of normal test results/values within the expected timeframe.	• Two of the 10 EHRs of patients with normal laboratory results did not contain documentation of patient notification.
	The facility complied with any additional elements required by VHA or local policy.	

Recommendations

8. We recommended that processes be strengthened to ensure that licensed independent practitioners are notified of critical laboratory test results/values within the expected timeframe and that notification is documented in the electronic health records and that compliance be monitored.

9. We recommended that processes be strengthened to ensure that all patients are notified of normal test results/values within the expected timeframe and that notification is documented in the electronic health records and that compliance be monitored.

Suicide Prevention Program

The purpose of this review was to evaluate the extent to which the facility's MH providers consistently complied with selected suicide prevention program requirements.[f]

We reviewed relevant documents and conversed with key employees. We also reviewed the EHRs of 30 patients assessed to be at high risk for suicide and the training records of 15 new employees. The table below shows the areas reviewed for this topic. The areas marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

NM	Areas Reviewed	Findings
	The facility had a full-time Suicide Prevention Coordinator and a plan for back-up.	
	The facility had a process for responding to referrals from the Veterans Crisis Line and for identifying and tracking patients who are at high risk for suicide.	
	The facility provided suicide prevention training to new staff and community organizations.	
	The facility issued required reports regarding any patients who attempted or completed suicide within the past 12 months.	
	The facility had a process to follow up on patients who missed MH appointments.	
	Patients had documented safety plans that specifically addressed suicidality.	
	Patients and/or their families participated in safety plan development.	
X	Safety plans contained all required elements.	• Five safety plans (17 percent) lacked documentation of assessment of available lethal means and ways to make the environment safe.
X	There was documented evidence that the patients and/or their families received a copy of the safety plan.	• Six patients' EHRs (20 percent) did not contain documentation that the patients and/or their families received a copy of the plan.
	Patient Record Flags were placed for high-risk patients.	
	The facility complied with any additional elements required by VHA or local policy.	

Recommendations

10. We recommended that processes be strengthened to ensure that safety plans contain documentation of assessment of available lethal means and ways to keep the environment safe and that compliance be monitored.

11. We recommended that processes be strengthened to ensure that patients and/or their families receive a copy of the safety plan and that compliance be monitored.

Management of Workplace Violence

The purpose of this review was to determine the extent to which the facility managed violent incidents.[9]

We reviewed relevant documents, 2 Reports of Contact from disruptive patient/employee/other (visitor) incidents that occurred during the 18-month period January 2013–July 2014, and 15 training records of employees who worked in areas at low, moderate, or high risk for violence. Additionally, we 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 had policies, procedures, or guidelines on preventing and managing violent behavior.	
	The facility conducted a Workplace Behavioral Risk Assessment to designate high-risk areas.	
	The facility had an Employee Threat Assessment Team, a Disruptive Behavior Committee/Board, and a prevention and management of disruptive behavior program disruptive behavior reporting and tracking system.	
	The facility used and tested appropriate physical security precautions and equipment in accordance with the local risk assessment.	
	The facility had an employee training plan that addressed the security issues of awareness, preparedness, precautions, and police assistance, and employees received the training defined in the plan.	
	Selected incidents were managed appropriately according to the facility's policies.	
	The facility complied with any additional elements required by VHA or local policy.	

MH RRTP

The purpose of this review was to determine whether the facility's domiciliary and Domiciliary Care for Homeless Veterans Program complied with selected EOC requirements.[h]

We reviewed relevant documents, inspected the domiciliary and Domiciliary Care for Homeless Veterans Program, and conversed with key employees. The table below shows the areas reviewed for this topic. The area marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

NM	Areas Reviewed	Findings
	The residential environment was clean and in good repair.	
NA	Appropriate fire extinguishers were available near grease producing cooking devices.	
	There were policies/procedures that addressed safe MM and contraband detection.	
	Monthly MH RRTP self-inspections were conducted, documented, and included all required elements; work orders were submitted for items needing repair; and any identified deficiencies were corrected.	
	Contraband inspections, staff rounds of all public spaces, daily bed checks, and resident room inspections for unsecured medications were conducted and documented.	
X	Written agreements acknowledging resident responsibility for medication security were in place.	• Written agreements were not in place in the domiciliary and the Domiciliary Care for Homeless Veterans Program.
	The main point(s) of entry had keyless entry and closed circuit television monitoring, and all other doors were locked to the outside and alarmed.	
	Closed circuit television monitors with recording capability were installed in public areas but not in treatment areas or private spaces, and there was signage alerting veterans and visitors that they were being recorded.	
	There was a process for responding to behavioral health and medical emergencies, and staff were able to articulate the process(es).	
NA	In mixed gender units, women veterans' rooms were equipped with keyless entry or door locks, and bathrooms were equipped with door locks.	

NM	Areas Reviewed (continued)	Findings
	Medications in resident rooms were secured.	
	The facility complied with any additional elements required by VHA or local policy.	

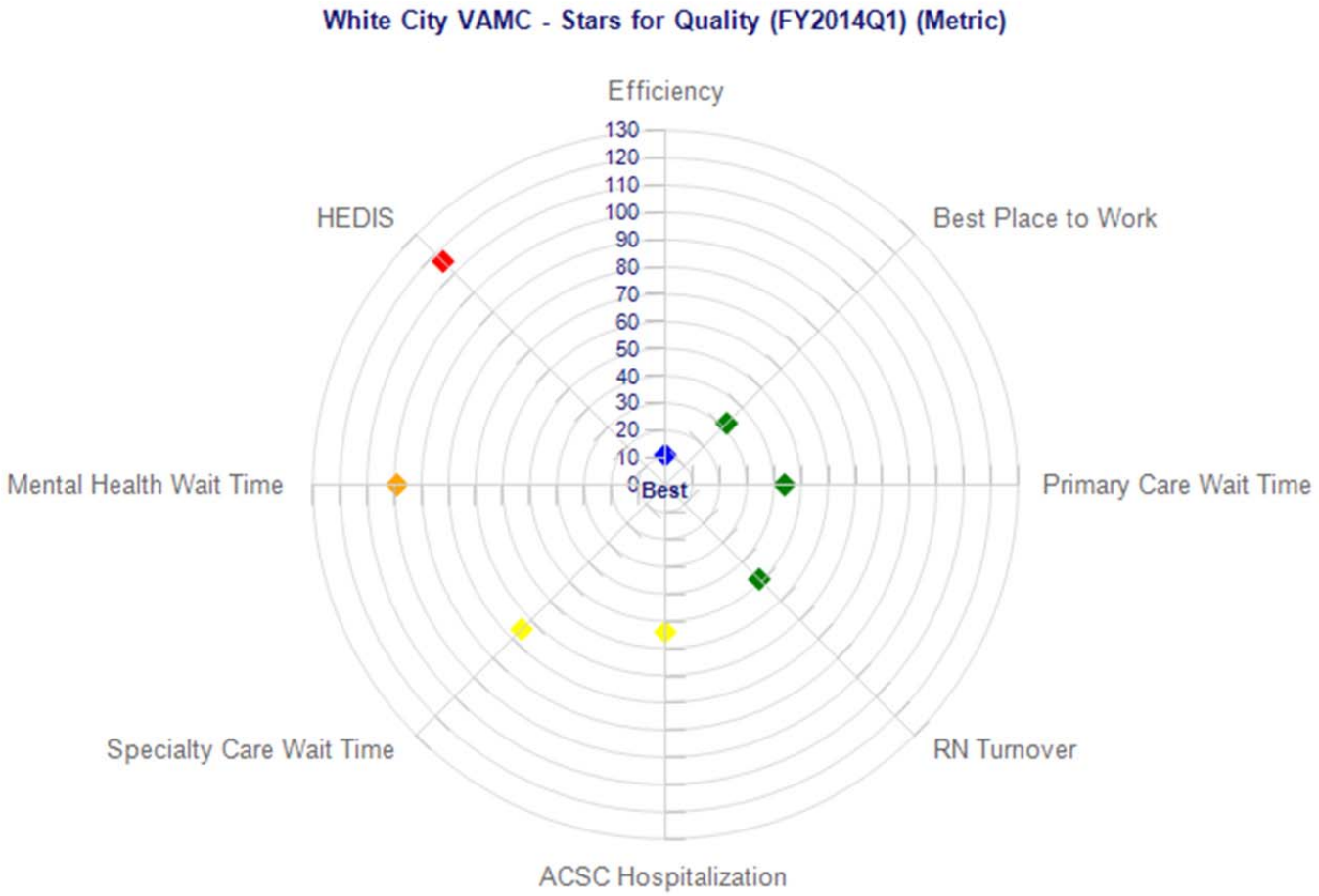
Recommendation

12. We recommended that processes be strengthened to ensure that written agreements acknowledging resident responsibility for medication security are in place in the domiciliary and the Domiciliary Care for Homeless Veterans Program and that compliance be monitored.

Facility Profile (White City/692) FY 2014 through June 2014[1]	
Type of Organization	Secondary
Complexity Level	3-Low complexity
Affiliated/Non-Affiliated	Affiliated
Total Medical Care Budget in Millions	$95.7
Number (as of July 2014) of:	
• **Unique Patients**	16,465
• **Outpatient Visits**	181,453
• **Unique Employees**[2]	503
Type and Number of Operating Beds:	
• **Hospital**	NA
• **CLC**	NA
• **MH**	525
Average Daily Census:	
• **Hospital**	NA
• **CLC**	NA
• **MH**	438
Number of Community Based Outpatient Clinics	2
Location(s)/Station Number(s)	Klamath Falls/692GA Grants Pass/692GB
VISN Number	20

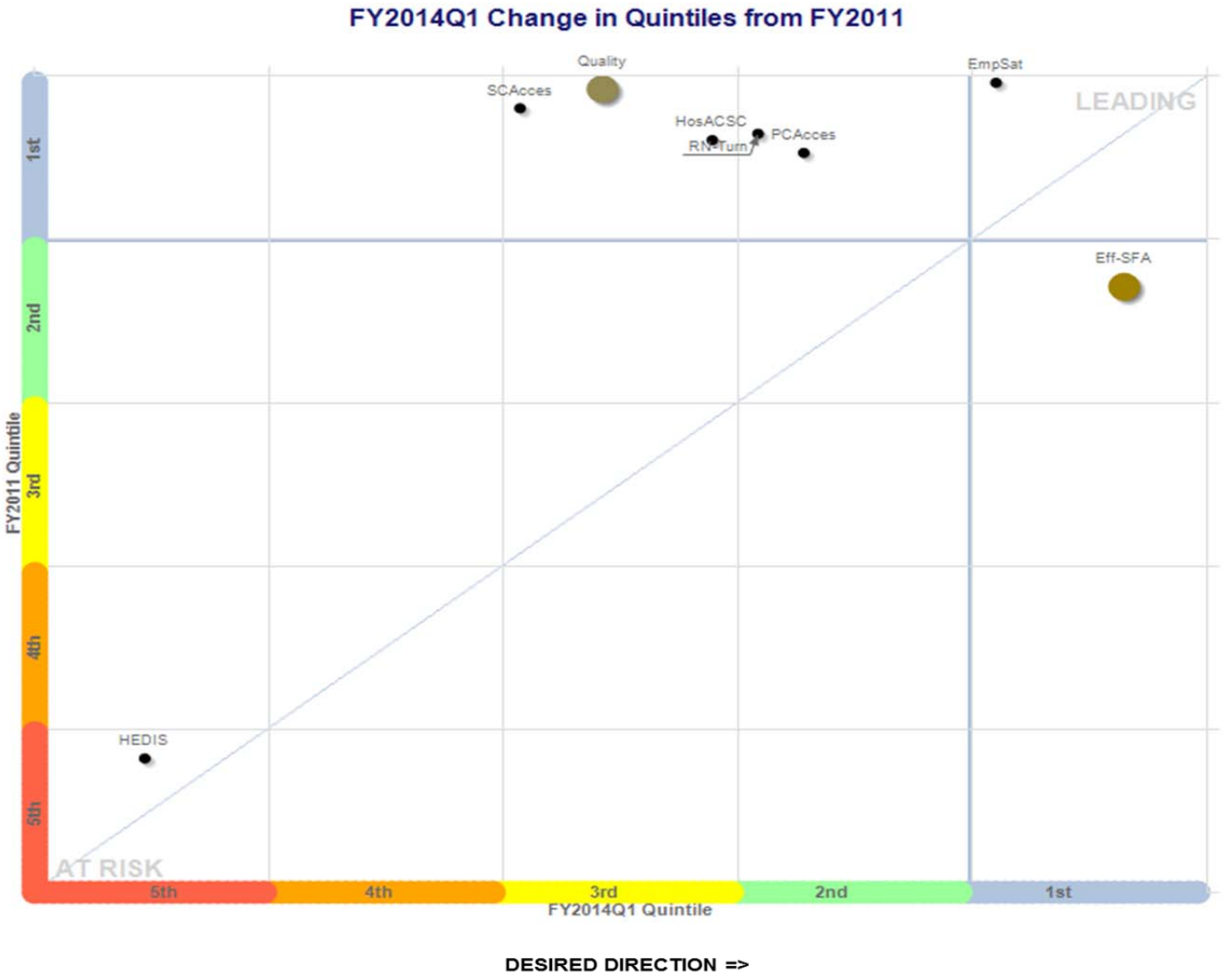
[1] All data is for FY 2014 through June 2014 except where noted.
[2] Unique employees involved in direct medical care (cost center 8200).

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



[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
Best Place to Work	Overall satisfaction with job	A higher value is better than a lower 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; FY13 and later)	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; FY13 and later)	A higher value is better than a lower value
PSI	Patient safety indicator (observed to expected ratio)	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; FY13 and later)	A higher value is better than a lower value

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: August 28, 2014

From: Director, Northwest Network (10N20)

Subject: **CAP Review of the VA Southern Oregon Rehabilitation Center and Clinics, White City, OR**

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

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

1. Thank you for the opportunity to respond to the proposed recommendations from the Combined Assessment Program Review at the VA Southern Oregon Rehabilitation Center and Clinics, White City, OR.

2. Attached please find the facility concurrences and responses to each of the findings from the review.

3. If you have additional questions or need further information, please contact Susan Green, Survey Coordinator, VISN 20 at (360) 567-4678.

(original signed by:)
Lawrence H. Carroll

Facility Director Comments

Department of Veterans Affairs **Memorandum**

Date: August 20, 2014

From: Director, VA Southern Oregon Rehabilitation Center and Clinics (692/00)

Subject: **CAP Review of the VA Southern Oregon Rehabilitation Center and Clinics, White City, OR**

To: Director, Northwest Network (10N20)

1. On behalf of the VA Southern Oregon Rehabilitation Center & Clinics (SORCC), White City Oregon. I would like to express my appreciation to the Office of Inspector General (OIG) Survey Team for their professionalism while completing the Combined Assessment Program (CAP) review conducted the week of July 21st, 2014.

2. We have reviewed and concurred with the findings from this report and have added SORCC's responses addressing each recommendation.

3. If you have any further questions regarding this report, please contact our Chief of Quality Management, Laurie Petersen at (541) 826-2111, extension 3625.

B. Don Burman

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 facility implement a quality control policy for scanning that includes all required elements.

Concur

Target date for completion: March 1, 2015

Facility response: Our facility has been approved to pilot a scanning unit with two Term scanning clerks who will be trained to scan all paper documents being incorporated into the electronic health record. This process is currently done in a decentralized fashion. The new protocol will be for the clerk to scan, self-verify accuracy on 100% of all scanned documents, stamp the document "scanned," and file for Quality Assurance (QA) review. The Lead Medical Record Tech will monitor 10% of scanned documents on a monthly basis, provide feedback to the scanning clerks and Health Information Management Service (HIMS) Chief, and shred the documents upon completion of the QA review. Scanning QA results will be reported to the Health Information Management Committee (HIMC) on a monthly basis and rolled up to Quality Leadership Committee (QLC) quarterly. Existing medical center memorandums will be modified to reflect this change to scanning protocol.

Recommendation 2. We recommended that processes be strengthened to ensure that infection prevention educational materials are available for eye clinic patients, visitors, and family members.

Concur

Target date for completion: August 23, 2014

Facility response: Our Infection Prevention Program immediately installed a wall brochure holder in the Eye Clinic and filled it with infection prevention educational materials for patients, visitors and family members.

Recommendation 3. We recommended that processes be strengthened to ensure that dirty items in the eye clinic are not stored in patient care areas and that compliance be monitored.

Concur

Target date for completion: August 29, 2014

Facility response: The housekeeping closet in Optometry will be converted to dirty utility room.

Recommendation 4. We recommended that processes be strengthened to ensure that employees reprocess ophthalmology pachymetry probes in accordance with manufacturer's instructions and that compliance be monitored.

Concur

Target date for completion: September 15, 2014

Facility response: The standard operation procedure (SOP) for pachymeter probe reprocessing has been revised to reflect manufacturer instructions. This SOP has been strengthened by including the specific instructions outlined by the manufacturer. Supply Processing Service (SPS) staff will be retrained in the new SOP and staff must demonstrate 100% competency by supervisor observation and documentation. Sustainability will be demonstrated through observation and supervisory documentation assuring staff are adhering to new SOP.

Recommendation 5. We recommended that facility policy be amended to include that Controlled Substances Coordinators must be free from conflicts of interest, that controlled substances inspectors must be appointed in writing, and that annual updates for controlled substances inspectors include problematic issues identified through external survey findings and other quality control measures.

Concur

Target date for completion: September 19, 2014

Facility response: Facility policy Inspection of Controlled Substance (MCM 11-002) will be amended to include:

(a) The Control Substances Coordinators are free from conflicts of interest;
(b) Control Substance Inspectors are appointed in writing by the Director; and
(c) Annual updates for Control Substance Inspectors include problematic issues identified through external survey findings and other quality control measures.

Recommendation 6. We recommended that the facility develop instructions for inspections of automated dispensing machines.

Concur

Target date for completion: September 19, 2014

Facility response: Facility policy Inspection of Controlled Substance (MCM 11-002 Attachment A, Inspection Memorandum) will be updated to reflect instructions for inspections of automated dispensing machines.

Recommendation 7. We recommended that processes be strengthened to ensure that the medical information from non-VA hospitalizations is consistently scanned into the electronic health records and that compliance be monitored.

Concur

Target date for completion: March 1, 2015

Facility response: We will assure that non-VA hospitalizations are consistently scanned into the electronic health records by increasing the number of facility scanners to complete the scanning. The facility will rely on the VHA Handbook 1907.01 Health Information Management and Health Records and VHA Directive 6300 Records Management as the framework to develop a facility protocol that outlines the process. This protocol will be approved by the Health Information Management Committee (HIMC) prior to implementation. In addition, Clinical and Business Office Staff will attend mandatory education. The anticipated date of implementation will be January 1, 2015. An audit of 15 random scanned medical records will be completed monthly and results reported to the HIMC and then rolled to Quality Leadership Committee quarterly.

Recommendation 8. We recommended that processes be strengthened to ensure that licensed independent practitioners are notified of critical laboratory test results/values within the expected timeframe and that notification is documented in the electronic health records and that compliance be monitored.

Concur

Target date for completion: March 1, 2015

Facility response: We will review and update our policy regarding Ordering and Reporting Test Results and Nursing Protocols. We will educate staff on the revised practices by distributing educational electronic messages, verbal communication and provide education in the monthly clinical staff meetings. Compliance will be monitored by doing 15 random medical records reviews per month to assure that messages are ultimately received by our License Independent Practitioners (LIP) and that this relay of information to LIPs occurs within the designated time frame. We will monitor for sustained improvement and report these results to the Medical Executive Committee (MEC) monthly and once the facility can assure 90% compliance the monitoring results will be reported to MEC quarterly.

Recommendation 9. We recommended that processes be strengthened to ensure that all patients are notified of normal test results/values within the expected timeframe and that notification is documented in the electronic health records and that compliance be monitored.

Concur

Target date for completion: March 1, 2015

Facility response: We will review and strengthen our processes to ensure that all patients are notified of test results within the expected time frame according to the type of study and the acuity of the result. We will follow the guidelines stated in our policy for Ordering and Reporting Test Results. We will continue to educate staff on these processes by distributing educational electronic messages, verbal communication and education in the monthly clinical staff meetings. Compliance will be monitored by doing 15 random medical record reviews per month and report our results to the Medical Executive Committee to confirm the communication of information to Veterans occurs within the designated time frame. We will monitor for sustained improvement and relay these results in 6 months.

Recommendation 10. We recommended that processes be strengthened to ensure that safety plans contain documentation of assessment of available lethal means and ways to keep the environment safe and that compliance be monitored.

Concur

Target date for completion: February 1, 2015

Facility response: The CPRS Suicide Safety Plan template will clarify what *Means Restrictions* need to occur and include the verbiage "Assessment of available lethal means and ways to keep the environment safe" as a mandatory text item. Staff will not be able to close the template until they have addressed the means restriction(s) with the Veteran. The Suicide Prevention Coordinator will train Mental Health Service line staff at department staff meetings by the end of October and the new process will implemented immediately. To ensure sustainability, we will randomly audit 20 medical records monthly to assure 90% compliance and report the results to the Rehabilitation Executive Committee.

Recommendation 11. We recommended that processes be strengthened to ensure that patients and/or their families receive a copy of the safety plan and that compliance be monitored.

Concur

Target date for completion: February 1, 2015

Facility response: The CPRS Suicide Safety Plan template will be updated and it will have the restriction(s) so that it cannot be signed or closed, unless the author addresses the reminder dialogue box which states "Veteran/family member given a copy of this plan." Our Suicide Prevention Coordinator will present at Mental Health Service Line Staff meetings through October. To ensure sustainability, we will randomly audit 20 medical records monthly to assure 90% compliance and report the results to the Rehabilitation Executive Committee.

Recommendation 12. We recommended that processes be strengthened to ensure that written agreements acknowledging resident responsibility for medication security are in place in the domiciliary and the Domiciliary Care for Homeless Veterans Program and that compliance be monitored.

Concur

Target date for completion: August 22, 2014

Facility response: The statement "Veterans are responsible to secure their own medications" has been added to the Admission Agreement to ensure that written agreements acknowledge the resident's responsibility for medication security. The Veteran will sign the iMed consent indicating that he/she has received this information. This responsibility is also included in the Facility Orientation and Section Orientation provided by the Admission staff and the Residential Care staff. Documentation of the education is now included in the admissions template for the medical record.

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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.
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- 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:
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- VHA Handbook 1108.02, *Inspection of Controlled Substances*, March 31, 2010.
- VHA Handbook 1108.05, *Outpatient Pharmacy Services*, May 30, 2006.
- VHA Handbook 1108.06, *Inpatient Pharmacy Services*, June 27, 2006.
- VHA, "Clarification of Procedures for Reporting Controlled Substance Medication Loss as Found in VHA Handbook 1108.01," Information Letter 10-2011-004, April 12, 2011.
- VA Handbook 0730, *Security and Law Enforcement*, August 11, 2000.
- VA Handbook 0730/2, *Security and Law Enforcement*, May 27, 2010.

[d] The references used for this topic were:
- VHA Handbook 1907.01, *Health Information Management and Health Records*, September 19, 2012.
- Various requirements of the Joint Commission.

[e] References used for this topic were:
- VHA Directive 2009-019, *Ordering and Reporting Test Results*, March 24, 2009.
- VHA Directive 1106, *Pathology and Laboratory Medicine Service*, April 5, 2013.
- VA Radiology, "Online Guide," http://vaww1.va.gov/RADIOLOGY/OnLine_Guide.asp, updated October 4, 2011.
- Various requirements of the Joint Commission.

[f] References used for this topic included:
- VHA Directive 2008-036, *Use of Patient Record Flags to Identify Patients at High Risk for Suicide*, July 18, 2008.
- VHA Handbook 1160.01, *Uniform Mental Health Services in VA Medical Centers and Clinics*, September 11, 2008.
- Deputy Under Secretary for Health for Operations and Management, "Patients at High Risk for Suicide," memorandum, April 24, 2008.
- Various requirements of the Joint Commission.

[g] References used for this topic were:
- VHA Directive 2009-008 (also listed as 2010-008), *Standards for Mental Health Coverage in Emergency Departments and Urgent Care Clinics in VHA Facilities*, February 22, 2010.
- VHA Directive 2012-026, *Sexual Assaults and Other Defined Public Safety Incidents in Veterans Health Administration (VHA) Facilities*, September 27, 2012.
- Under Secretary for Health, "Violent Behavior Prevention Program," Information Letter 10-97-006, February 3, 1997.
- Various requirements of the Occupational Safety and Health Administration.

[h] References used for this topic were:
- VHA Handbook 1162.02, *Mental Health Residential Rehabilitation Treatment Program (MH RRTP)*, December 22, 2010.
- VHA Handbook 1330.01, *Health Care Services for Women Veterans*, May 21, 2010.
- Requirements of the VHA Center for Engineering and Occupational Safety and Health and the National Fire Protection Association.