Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 14-02070-305

Combined Assessment Program Review of the Alexandria VA Health Care System Pineville, Louisiana

October 16, 2014

Washington, DC 20420

To Report Suspected Wrongdoing in VA Programs and Operations
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(Hotline Information: www.va.gov/oig/hotline)

Glossary

CAP	Combined Assessment Program
CLC	community living center
EHR	electronic health record
EOC	environment of care
facility	Alexandria VA Health Care System
FY	fiscal year
MEC	Medical Executive Committee
MH	mental health
MRI	magnetic resonance imaging
NA	not applicable
NM	not met
OIG	Office of Inspector General
PACU	post-anesthesia care unit
PRC	Peer Review Committee
QM	quality management
SDS	same day surgery
tPA	tissue plasminogen activator
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 August 4, 2014.

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

- Medication Management
- Coordination of Care

Recommendations: We made recommendations in the following five activities:

Quality Management: Ensure that the Inpatient Management Committee reviews each code episode and that code data is collected. Require the Surgical Review Committee to document its review of National Surgical Office reports and monitoring of surgery performance improvement activities. Ensure the Blood Usage, Surgical, and Other Invasive Procedures Review Committee members from Medicine, Surgery, and Anesthesia Services consistently attend meetings.

Environment of Care: Ensure that patient care areas and public restrooms are clean and in good repair. Require that all designated same day surgery and eye clinic employees receive laser safety training in accordance with facility policy.

Acute Ischemic Stroke Care: Revise the stroke policy to address the difference in approach to patients presenting with symptoms within the facility's defined timeframe to be eligible for tissue plasminogen activator and those presenting outside the defined timeframe. Complete and document National Institutes of Health stroke scales for each stroke patient. Screen patients for difficulty swallowing prior to oral intake. Provide printed stroke education to patients upon discharge. Collect and report to the Veterans Health Administration and the Executive Committee of the Medical Staff the percent of eligible patients given tissue plasminogen activator, the percent of patients with stroke symptoms who had the stroke scale completed, and the percent of patients screened for difficulty swallowing before oral intake.

Community Living Center Resident Independence and Dignity: Offer restorative nursing services.

Magnetic Resonance Imaging Safety: Conduct emergency drills in magnetic resonance imaging (MRI). Conduct initial patient safety screenings. Ensure Level 2 MRI personnel conducting secondary patient safety screenings sign the forms prior to MRI. Require that radiologists and/or Level 2 MRI personnel document resolution in patients' electronic health records of all identified MRI contraindications prior to the scan.

Designate Level 1 ancillary staff, and ensure they receive annual level-specific MRI safety training. Place appropriate signs to identify MRI Zones III and IV.

Comments

The Veterans Integrated Service Network Director and Facility Director agreed with the Combined Assessment Program review findings and recommendations and provided acceptable improvement plans. (See Appendixes C and D, pages 20–28, 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 2012, FY 2013, and FY 2014 through August 4, 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 Alexandria VA Health Care System, Pineville, Louisiana,* Report No. 12-00885-200, June 14, 2012.

During this review, we presented crime awareness briefings for 223 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 225 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.

Results and Recommendations

QM

The purpose of this review was to determine whether facility senior managers actively supported and appropriately responded to QM efforts and whether the facility met selected requirements within its QM program.[a]

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

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

NM	Areas Reviewed (continued)	Findings
	Observation bed use met selected requirements: • Local policy included necessary elements. • Data regarding appropriateness of observation bed usage was gathered. • If conversions to acute admissions were consistently 30 percent or more, observation criteria and utilization were reassessed timely.	
	Staff performed continuing stay reviews on at least 75 percent of patients in acute beds.	
X	The process to review resuscitation events met selected requirements: • An interdisciplinary committee was responsible for reviewing episodes of care where resuscitation was attempted. • Resuscitation event reviews included screening for clinical issues prior to events that may have contributed to the occurrence of the code. • Data were collected that measured performance in responding to events.	One month of Critical Care Committee (replaced by the Inpatient Management Committee) meeting minutes reviewed: • There was no evidence that the committee reviewed each episode. • There was no evidence that data were collected.
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.	Four months of Surgical Review Committee meeting minutes reviewed: • There was no evidence that National Surgical Office reports were reviewed. • There was no evidence that surgery performance improvement activities were monitored.
	Critical incidents reporting processes were appropriate.	
	The process to review the quality of entries in the EHR met selected requirements: • A committee was responsible to review EHR quality. • Data were collected and analyzed at least quarterly. • Reviews included data from most services and program areas.	
	The policy for scanning non-VA care documents met selected requirements.	

NM	Areas Reviewed (continued)	Findings
X	The process to review blood/transfusions usage met selected requirements: • A committee with appropriate clinical membership met at least quarterly to review blood/transfusions usage. • Additional data elements were routinely reviewed.	Twelve months of Blood Usage, Surgical, and Other Invasive Procedures Review Committee meeting minutes reviewed: • Clinical representatives from Surgery and Anesthesia Services did not attend any meetings, and the Medicine Service representative attended only 8 of 12 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 processes be strengthened to ensure that the Inpatient Management Committee reviews each code episode and that code data is collected.

2. We recommended that the Surgical Review Committee document its review of National Surgical Office reports and monitoring of surgery performance improvement activities.

3. We recommended that processes be strengthened to ensure that the Blood Usage, Surgical, and Other Invasive Procedures Review Committee members from Medicine, Surgery, 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 medicine unit, the telemetry unit, the acute MH unit, two CLCs, SDS, the operating room, the PACU, the urgent care clinic, the eye clinic, the orthopedic clinic, and a primary care clinic. Additionally, we reviewed relevant documents, conversed with key employees and managers, and reviewed 17 employee training records (10 SDS, 2 SDS/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
	EOC Committee minutes reflected sufficient detail regarding identified deficiencies, corrective actions taken, and tracking of corrective actions to closure.	
	An infection prevention risk assessment was conducted, and actions were implemented to address high-risk areas.	
	Infection Prevention/Control Committee minutes documented discussion of identified problem areas and follow-up on implemented actions and included analysis of surveillance activities and data.	
	Fire safety requirements were met.	
X	Environmental safety requirements were met.	• Five of eight patient care areas had damaged or dirty furnishings, damaged or dirty floors/baseboards, and/or mold. • Five of eight public restrooms were dirty and/or had damaged fixtures and walls.
	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	
	Designated SDS and PACU employees received bloodborne pathogens training during the past 12 months.	
X	Designated SDS employees received medical laser safety training with the frequency required by local policy.	• None of the 10 SDS employees received medical laser safety training.

NM	Areas Reviewed for SDS and the PACU (continued)	Findings
	Fire safety requirements in SDS and on the PACU were met.	
	Environmental safety requirements in SDS and on the PACU were met.	
	SDS medical laser safety requirements were met.	
	Infection prevention requirements in SDS and on the PACU were met.	
	Medication safety and security requirements in SDS and on the PACU were met.	
	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	
X	Designated eye clinic employees received laser safety training with the frequency required by local policy.	• Four of the five eye clinic employees did not receive laser safety training.
	Environmental safety requirements in the eye clinic were met.	
	Infection prevention requirements in the eye clinic were met.	
	Medication safety and security requirements in the eye clinic were met.	
	Laser safety requirements in the eye clinic were met.	
	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.	

Recommendations

4. We recommended that processes be strengthened to ensure that patient care areas are clean and in good repair and that compliance be monitored.

5. We recommended that processes be strengthened to ensure that public restrooms are clean and in good repair and that compliance be monitored.

6. We recommended that processes be strengthened to ensure that all designated same day surgery and eye clinic employees receive laser safety training in accordance with facility policy 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 34 randomly selected inpatients discharged on 1 of 3 selected oral antibiotics. The table below shows the areas reviewed for this topic. Any items that did not apply to this facility are marked NA. The facility generally met requirements. We made no recommendations.

NM	Areas Reviewed	Findings
	Clinicians conducted inpatient learning assessments within 24 hours of admission or earlier if required by local policy.	
	If learning barriers were identified as part of the learning assessment, medication counseling was adjusted to accommodate the barrier(s).	
NA	Patient renal function was considered in fluoroquinolone dosage and frequency.	
	Providers completed discharge progress notes or discharge instructions, written instructions were provided to patients/caregivers, and EHR documentation reflected that the instructions were understood.	
	Patients/caregivers were provided a written medication list at discharge, and the information was consistent with the dosage and frequency ordered.	
	Patients/caregivers were offered medication counseling, and this was documented in patient EHRs.	
	The facility established a process for patients/caregivers regarding whom to notify in the event of an adverse medication event.	
	The facility complied with any additional elements required by VHA or local policy.	

Coordination of Care

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

We reviewed relevant documents and conversed with key employees. Additionally, we reviewed the EHRs of 16 patients with specific diagnoses who were discharged from July 1, 2012, through June 30, 2013. The table below shows the areas reviewed for this topic. Any items that did not apply to this facility are marked NA. The facility generally met requirements. We made no recommendations.

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

Acute Ischemic Stroke Care

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

We reviewed relevant documents, the EHRs of 25 randomly selected patients who experienced stroke symptoms, and 10 employee training records (5 urgent care center and 5 medical-surgical unit), and we conversed with key employees. We also conducted onsite inspections of the urgent care center, three acute inpatient units, and two CLCs. 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's stroke policy/plan/guideline addressed all required items.	• The facility's policy did not address the difference in approach to patients presenting within the facility's defined timeframe to be eligible for tPA and those presenting outside the defined timeframe.
X	Clinicians completed the National Institutes of Health stroke scale for each patient within the expected timeframe.	• None of the 15 applicable EHRs contained documented evidence of completed stroke scales.
NA	Clinicians provided medication (tPA) timely to halt the stroke and included all required steps, and tPA was in stock or available within 15 minutes.	
	Stroke guidelines were posted in all areas where patients may present with stroke symptoms.	
X	Clinicians screened patients for difficulty swallowing prior to oral intake of food or medicine.	• Seven of the 17 applicable EHRs did not contain documentation that patients were screened for difficulty swallowing prior to oral intake.
X	Clinicians provided printed stroke education to patients upon discharge.	• None of the 11 applicable EHRs contained documentation that stroke education was provided to the patient/caregiver.
	The facility provided training to staff involved in assessing and treating stroke patients.	
X	The facility collected and reported required data related to stroke care.	• There was no evidence that the following data were collected and reported to VHA or the Executive Committee of the Medical Staff: o Percent of eligible patients given tPA o Percent of patients with stroke symptoms who had the stroke scale completed o Percent of patients screened for difficulty swallowing before oral intake
	The facility complied with any additional elements required by VHA or local policy.	

Recommendations

7. We recommended that the facility's stroke policy be revised to address the difference in approach to patients presenting with symptoms within the facility's defined timeframe to be eligible for tissue plasminogen activator and those presenting outside the defined timeframe and that compliance be monitored.

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

9. We recommended that processes be strengthened to ensure that clinicians screen patients for difficulty swallowing prior to oral intake and that compliance be monitored.

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

11. We recommended that the facility collect and report to VHA and the Executive Committee of the Medical Staff the percent of eligible patients given tissue plasminogen activator, the percent of patients with stroke symptoms who had the stroke scale completed, and the percent of patients screened for difficulty swallowing before oral intake.

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 observed two meal periods 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
X	The facility offered restorative nursing services.	• The facility did not offer restorative nursing services in the CLC.
NA	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.	
NA	Resident progress towards restorative nursing goals was documented, and interventions were modified as needed to promote the resident's accomplishment of goals.	
NA	When restorative nursing services were care planned but were not provided or were discontinued, reasons were documented in the EHR.	
NA	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.	
NA	Training and competency assessment were completed for staff who performed restorative nursing services.	
NA	The facility complied with any additional elements required by VHA or local policy.	
	Areas Reviewed for Assistive Eating Devices and Dining Service	
NA	Care planned/ordered assistive eating devices were provided to residents at meal times.	
	Required activities were performed during resident meal periods.	
NA	The facility complied with any additional elements required by VHA or local policy.	

Recommendation

12. We recommended that the facility offer restorative nursing services and that compliance be monitored.

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 34 employees (30 randomly selected Level 1 ancillary staff and 4 designated Level 2 MRI personnel), and we conversed with key managers and employees. We also reviewed the EHRs of 28 randomly selected patients who had an MRI January 1–December 31, 2013. Additionally, we conducted a physical inspection of one MRI area. 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.	• Emergency drills were not conducted in the MRI area.
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.	• None of the EHRs contained initial patient safety screenings. • Fourteen secondary patient safety screening forms were not signed by Level 2 MRI personnel 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.	• None of the seventeen applicable EHRs contained documentation that all identified 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 were designated or received level-specific MRI safety training.
X	Signage and barriers were in place to prevent unauthorized or accidental access to Zones III and IV.	• The facility had no signage to indicate restriction to Zones III and IV.
	MRI technologists maintained visual contact with patients in the magnet room and two-way communication with patients inside the magnet, and the two-way communication device was regularly tested.	
	Patients were offered MRI-safe hearing protection for use during the scan.	
	The facility had only MRI-safe or compatible equipment in Zones III and IV, or the equipment was appropriately protected from the magnet.	
	The facility complied with any additional elements required by VHA or local policy.	

Recommendations

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

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

15. We recommended that processes be strengthened to ensure that Level 2 magnetic resonance imaging personnel conducting secondary patient safety screenings sign the forms prior to magnetic resonance imaging and that compliance be monitored.

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

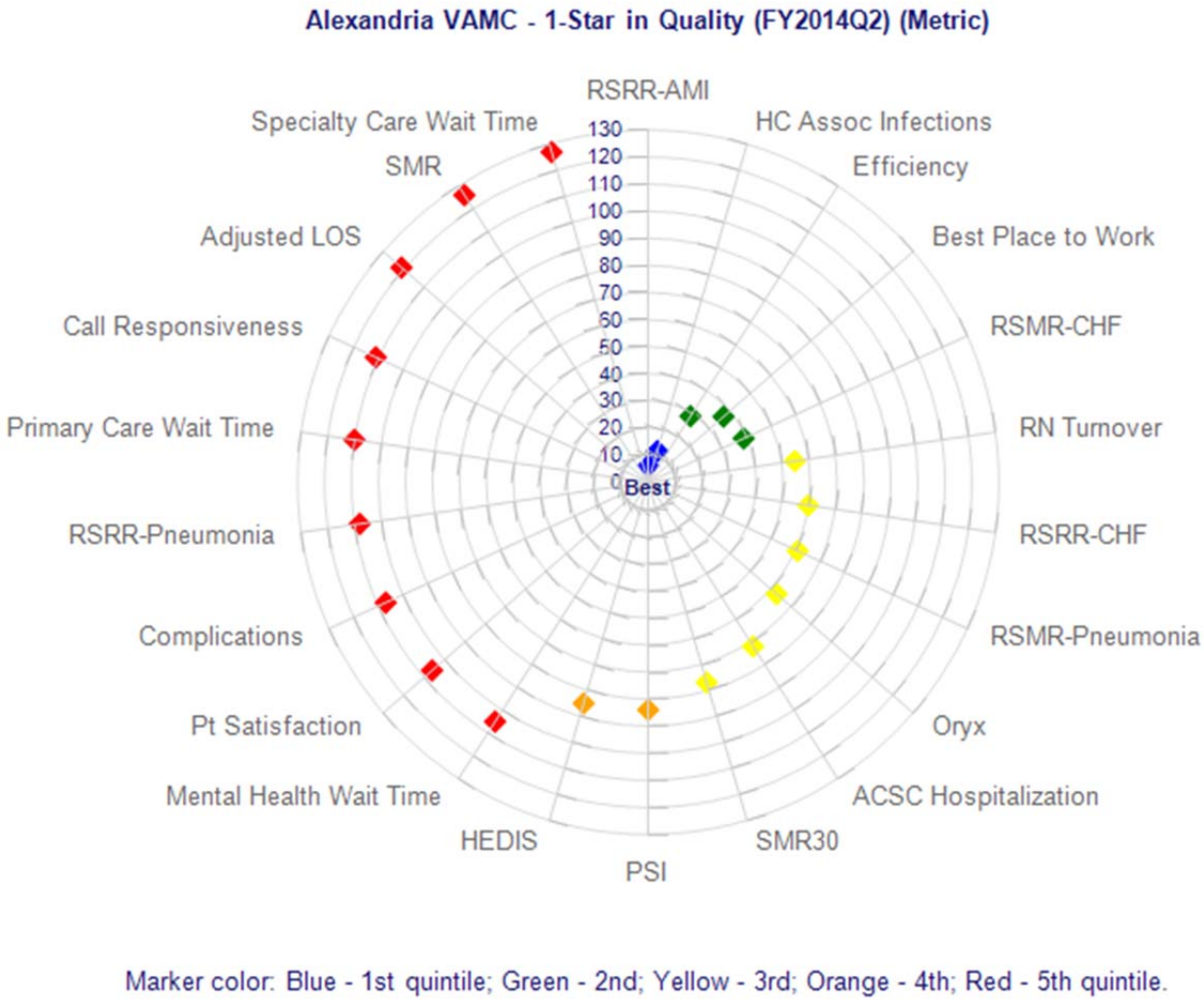
17. We recommended that the facility designate Level 1 ancillary staff, that processes be strengthened to ensure that Level 1 ancillary staff receive annual level-specific magnetic resonance imaging safety training, and that compliance with training be monitored.

18. We recommended that appropriate signage be in place to identify magnetic resonance imaging Zones III and IV.

Facility Profile (Alexandria/502) FY 2014 through August 2014[1]	
Type of Organization	Secondary
Complexity Level	3-Low complexity
Affiliated/Non-Affiliated	Affiliated
Total Medical Care Budget in Millions	$194.9
Number of:	
• **Unique Patients**	30,450
• **Outpatient Visits**	270,082
• **Unique Employees**[2]	994
Type and Number of Operating Beds (as of July 2014):	
• **Hospital**	105
• **CLC**	154
• **MH**	NA
Average Daily Census (as of July 2014):	
• **Hospital**	58
• **CLC**	74
• **MH**	NA
Number of Community Based Outpatient Clinics	4
Location(s)/Station Number(s)	Jennings/502GA Lafayette Parish/502GB Fort Polk/502GF Natchitoches/502GG
VISN Number	16

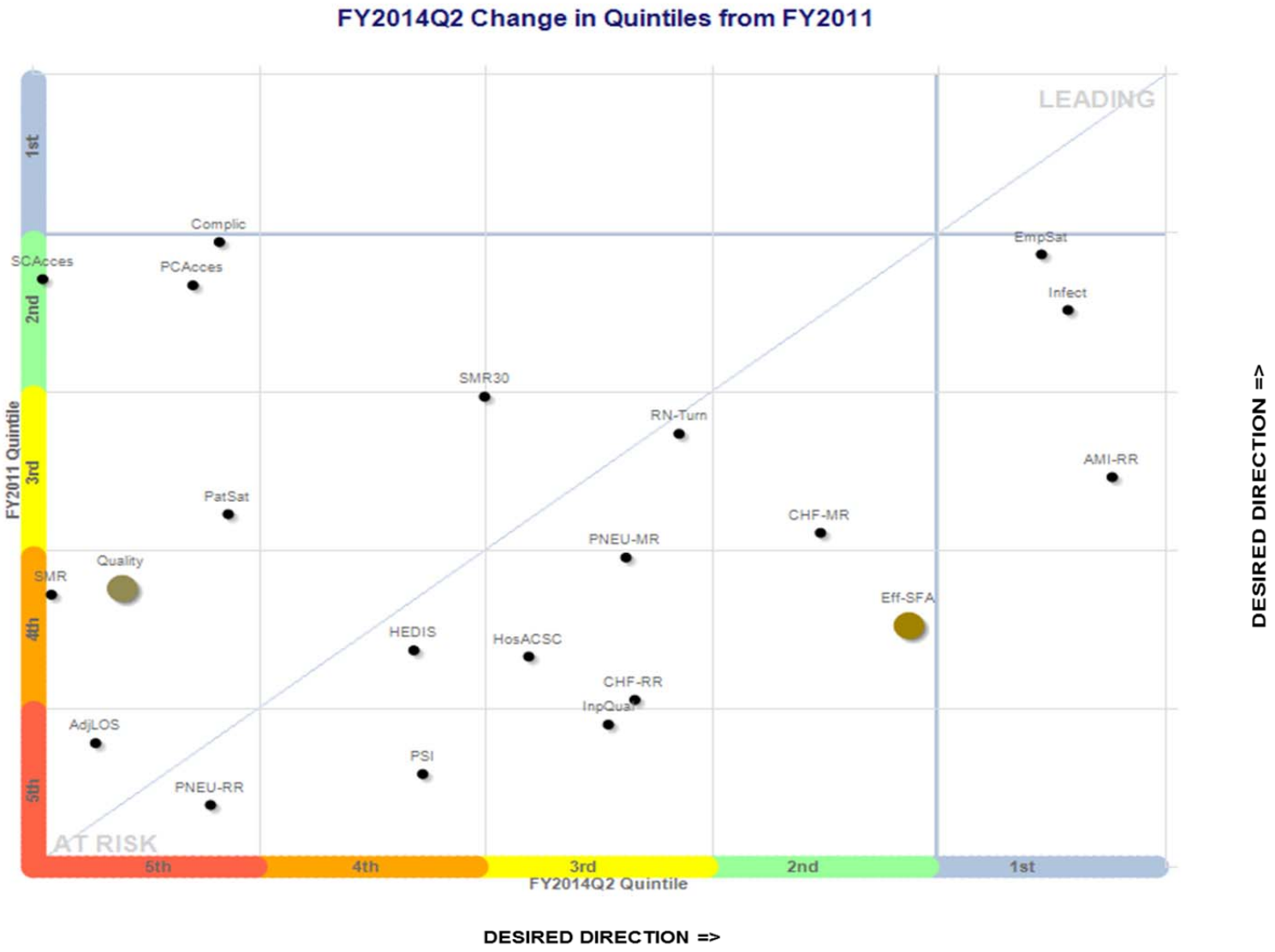
[1] All data is for FY 2014 through August 2014 except where noted.
[2] Unique employees involved in direct medical care (cost center 8200) from most recent pay period.

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



[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: September 24, 2014

From: Director, South Central VA Health Care Network (10N16)

Subject: **CAP Review of the Alexandria VA Health Care System, Pineville, LA**

To: Director, Dallas Office of Healthcare Inspections (54DA)

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

1. The South Central VA Health Care Network has reviewed and concurs with the action plan provided in response to the draft report submitted for the Alexandria VA Health Care System, Pineville, LA.

2. If you have questions or need additional information, please contact Reba T. Moore, VISN 16 Accreditation Specialist at (601) 206-7022.

Rica Lewis-Payton, MHA, FACHE

Facility Director Comments

Department of Veterans Affairs **Memorandum**

Date: September 23, 2014

From: Director, Alexandria VA Health Care System (502/00)

Subject: **CAP Review of the Alexandria VA Health Care System, Pineville, LA**

To: Director, South Central VA Health Care Network (10N16)

I concur with the recommendations contained within this report. Our responses are included.

Martin J. Fraxler
Director, Alexandria VA Health Care System (502/00)

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 processes be strengthened to ensure that the Inpatient Management Committee reviews each code episode and that code data is collected.

Concur

Target date for completion: December 22, 2014

Facility response: The facility governance structure has been revised to reflect the Inpatient Management Committee (IMC) reporting of code episodes and code data collection outcomes to the Healthcare Delivery Committee (HDC). The leadership for the IMC has been revised. HDC has revised its reporting schedule and IMC reports will be monitored more closely. Compliance with the established reporting schedule will be reported by the HDC to the Joint Advisory Governing Board. The minutes will be monitored to ensure compliance.

Recommendation 2. We recommended that the Surgical Review Committee document its review of National Surgical Office reports and monitoring of surgery performance improvement activities.

Concur

Target date for completion: November 1, 2014

Facility response: Effective August 2014, Morbidity and Mortality/Surgical Work Group Minutes will reflect documentation of National Surgical Office report and surgery performance improvement activities review with minutes/monitors embedded within.

Recommendation 3. We recommended that processes be strengthened to ensure that the Blood Usage, Surgical, and Other Invasive Procedures Review Committee members from Medicine, Surgery, and Anesthesia Services consistently attend meetings.

Concur

Target date for completion: November 1, 2014

Facility response: An updated recurring meeting appointment was sent to all members on their Microsoft Outlook calendar. Attendance will be recorded in the minutes. A review of required committee members was conducted to consolidate membership.

The Acting Chief, Medical Service and Chief, Specialty Care Service has designated specific staff to attend the meetings on their behalf.

Recommendation 4. We recommended that processes be strengthened to ensure that patient care areas are clean and in good repair and that compliance be monitored.

Concur

Target date for completion: December 1, 2014

Facility response: Effective August 2014, additional EMS staff have been assigned to patient care areas to improve cleanliness. In addition to recurring EOC rounds, supervisors revised daily walk thru inspection timeframes. The EMS service chief has also reinforced to EMS supervisors that they should ensure work orders are sent to Engineering Service when the need for repairs are identified. Will continue to monitor to ensure compliance.

Recommendation 5. We recommended that processes be strengthened to ensure that public restrooms are clean and in good repair and that compliance be monitored.

Concur

Target date for completion: December 1, 2014

Facility response: EMS has detailed all public restrooms. On 8/25/14 a list of sinks and toilets in need of repair was sent to Engineering Service. A schedule for the cleaning of all public restrooms has been established. Restrooms will be cleaned daily and detailed as needed. The EMS service chief has also reinforced to EMS supervisors that they should ensure work orders are sent to Engineering Service when the need for repairs are identified. Will continue to monitor to ensure compliance.

Recommendation 6. We recommended that processes be strengthened to ensure that all designated same day surgery and eye clinic employees receive laser safety training in accordance with facility policy and that compliance be monitored.

Concur

Target date for completion: September 30, 2014

Facility response: 99% of employees have completed laser safety training. One employee (Fee Basis) is due to complete laser safety training in September 2014. Compliance will be monitored monthly by the Administrative Officer for Specialty Care Service for new employee completion of training. Laser Safety training course was assigned in Talent Management System (TMS) as an annual training requirement for designated same day surgery and eye clinic employees to be completed annually.

Recommendation 7. We recommended that the facility's stroke policy be revised to address the difference in approach to patients presenting with symptoms within the facility's defined timeframe to be eligible for tissue plasminogen activator and those presenting outside the defined timeframe and that compliance be monitored.

Concur

Target date for completion: October 31, 2014

Facility response: The facility's stroke policy [HCSM 111-10, Management of Acute Ischemic Stroke (AIS) Patients)] has been revised to include the elements identified in the recommendation. The HCSM 110-10, Management of Acute Ischemic Stroke (AIS) Patients is on the 9/23/14 Healthcare Delivery Committee Agenda for approval. Once approved, it will be submitted for electronic concurrence.

Recommendation 8. We recommended that processes be strengthened to ensure that clinicians complete and document National Institutes of Health stroke scales for each stroke patient and that compliance be monitored.

Concur

Target date for completion: December 31, 2014

Facility response: An NIHSS template will be updated and submitted to the Medical Records Committee (MRC) for approval to be embedded in the UCC Provider Note, UCC Nursing Note, acute inpatient notes for Medicine/MH and for CLC notes. The template requests have been submitted to the Clinical Applications Coordinator and the build is scheduled for completion and implementation by September 30, 2014. Nursing Service and Medical Service will co-manage monitoring of compliance and reporting to the Inpatient Management Committee on a quarterly basis.

Recommendation 9. We recommended that processes be strengthened to ensure that clinicians screen patients for difficulty swallowing prior to oral intake and that compliance be monitored.

Concur

Target date for completion: December 31, 2014

Facility response: Revised HCSM 111-10 will address this area. All patients with AIS symptoms will be NPO until final disposition. The following process will be implemented: The dysphagia screen will be ordered by the provider and completed by nursing. The template for documentation of the dysphagia screen and an action plan for education/training for those staff who will complete the screen (those currently on staff and new hires) was developed by Nursing Education and Lead Speech Pathologist. Education/training of identified nursing staff who will be responsible for

completing the screen will be completed by 9/30/14. Nursing Education will monitor compliance beginning in October 2014 to include the following:

- Education of the identified staff completed-target 95%
- Number of patients having the dysphagia screen completed divided by total number of patients AIS-target 100%

Reporting of results will be to the Nursing Process Improvement Committee and Inpatient Management Committee until a period of 3 months of sustainability is achieved.

Recommendation 10. We recommended that processes be strengthened to ensure that clinicians provide printed stroke education to patients upon discharge and that compliance be monitored.

Concur

Target date for completion: December 31, 2014

Facility response: On August 14, 2014, the ACNS/Education instructed nursing staff to provide printed educational material on stroke to all patients diagnosed with AIS. She also instructed them to document in Patient Education Note that patient has been provided printed educational material and has received education on the signs of a stroke and what to do. Education material (2) has been provided to nursing staff to give to all patients diagnosed with AIS. 15 patients will be audited per month to ensure Patient Education Note is being used to document printed education material given and education on signs of a stroke and what to do. This information will be tracked through Inpatient Management Committee until a period of 3 consecutive months of sustainability has been reached.

Recommendation 11. We recommended that the facility collect and report to VHA and the Executive Committee of the Medical Staff the percent of eligible patients given tissue plasminogen activator, the percent of patients with stroke symptoms who had the stroke scale completed, and the percent of patients screened for difficulty swallowing before oral intake.

Concur

Target date for completion: December 31, 2014

Facility response: The AIS quality indicators have been added to Medical Service Performance Improvement monitoring. Data collection will include the percent of eligible patients given tissue plasminogen activator, the percent of patients with stroke symptoms who had the stroke scale completed, and the percent of patients screened for difficulty swallowing before oral intake. The first report will be submitted to the Healthcare Delivery Committee (formerly the Executive Committee of the Medical Staff) and IPEC during Quarter 1 FY 15. Nursing Service and Medical Service will co-manage monitoring of compliance and reporting to the Committee on a quarterly basis.

Recommendation 12. We recommended that the facility offer restorative nursing services and that compliance be monitored.

Concur

Target date for completion: December 31, 2014

Facility response: The implementation of the Pilot Restorative Program took place on 8/19/2014. Approximately 13–17 Residents will be added per month until all residents appropriate for a Restorative Program are included. In order to make sure that new staff who come to work in the CLC are involved in the program, the CLC new employee orientation has been revised to include the Restorative Care Program.

Recommendation 13. We recommended that processes be strengthened to ensure that emergency drills are conducted in magnetic resonance imaging and that compliance be monitored.

Concur

Target date for completion: September 30, 2014

Facility response: The Chief of Magnetic Resonance Imaging (MRI) met with the Chief of the Fire Department and the Environmental Specialist on 8/13/14 to schedule and plan emergency drills the week of August 25th. An emergency drill with Fire and Police was completed on 8/21/14 at 16:30 in MRI Service. Mental Health Emergency Drill and CPR Emergency Drills will be conducted during the month of September 2014. All emergency drills in MRI will be completed on an annual basis. Monitoring will occur to ensure compliance.

Recommendation 14. 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: November 15, 2014

Facility response: Effective 8/7/14, initial safety screenings are now completed at the Imaging reception desk. The radiology clerk will sign to verify. The secondary, more intense screening will be completed and signed by the technologist and patient. The initial MRI screening process will be monitored monthly to ensure compliance. Imaging will monitor the number of patients with screening forms/total number of patients scanned.

Recommendation 15. We recommended that processes be strengthened to ensure that Level 2 magnetic resonance imaging personnel conducting secondary patient safety screenings sign the forms prior to magnetic resonance imaging and that compliance be monitored.

Concur

Target date for completion: November 15, 2014

Facility response: Effective 8/6/2014, all MRI technologists will sign, not initial, the MRI screening forms. The secondary MRI screening process will be monitored for signatures on a monthly basis. Imaging will monitor the number of signatures/total number of forms.

Recommendation 16. We recommended that processes be strengthened to ensure that radiologists and/or Level 2 magnetic resonance imaging personnel document resolution in 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: November 15, 2014

Facility response: Effective 8/6/14, documentation of contraindications are documented on the MRI screening form which is scanned into the medical record and initialed by the technologist after the Radiologist approves. Documentation of MRI contraindications on the screening forms will be monitored monthly by measuring the # of MRI screening forms with contraindications/Total number of MRI patients with contraindications.

Recommendation 17. We recommended that the facility designate Level 1 ancillary staff, that processes be strengthened to ensure that Level 1 ancillary staff receive annual level-specific magnetic resonance imaging safety training, and that compliance with training be monitored.

Concur

Target date for completion: November 15, 2014

Facility response: Effective 8/15/14, Imaging will determine which ancillary staff require Level I MRI Safety Training by consulting with the Associate Director-Patient Care Services. All Police, Fire, Code Team, and Urgent Care Nurses will be assigned Level I MRI Safety Training by Education Service through TMS on an annual basis.

Recommendation 18. We recommended that appropriate signage be in place to identify magnetic resonance imaging Zones III and IV.

Concur

Target date for completion: October 1, 2014

Facility response: Signs were ordered on 8/7/14. Order shipped on 9/9/14. Awaiting delivery and installation.

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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.
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- VHA Directive 2009-064, *Recording Observation Patients*, November 30, 2009.
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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:
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- 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 1108.05, *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®.
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[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:
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- 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.
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