Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 14-02071-02

Combined Assessment Program Review of the VA Long Beach Healthcare System Long Beach, California

October 14, 2014

Washington, DC 20420

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

Glossary

CAP	Combined Assessment Program
CLC	community living center
EHR	electronic health record
EMS	Environmental Management Service
EOC	environment of care
facility	VA Long Beach Healthcare System
FY	fiscal year
HF	heart failure
MEC	Medical Executive Committee
MH	mental health
MRI	magnetic resonance imaging
NA	not applicable
NCM	nurse case managers
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

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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:

- Coordination of Care

The facility's reported accomplishments were an improved bed management system, a redesigned outpatient pharmacy dispensing project, and an evidenced-based nurse case management initiative for heart failure.

Recommendations: We made recommendations in the following seven activities:

Quality Management: Ensure that the Resuscitation Services Committee reviews each code episode and that code reviews include screening for clinical issues prior to the code that may have contributed to the occurrence of the code.

Environment of Care: Require that Environment of Care Committee minutes and the environment of care rounds database accurately reflect whether deficiencies were resolved. Ensure that patient care areas and public restrooms are clean and free from offensive odors and that walls, counters, floors, and furnishings in these areas are in good repair. Require that equipment items receive appropriate maintenance and preventive maintenance and that electrical inspections stickers are current. Store clean and dirty items separately. Promptly remove expired medications from patient care areas, and secure medications at all times.

Medication Management: Document patient learning assessments within 24 hours of admission. Ensure clinicians conducting medication education accommodate identified learning barriers and document the accommodations made to address those barriers.

Acute Ischemic Stroke Care: Complete and document National Institutes of Health stroke scales for each stroke patient. Screen patients for difficulty swallowing prior to oral intake, and provide patients with printed stroke education materials upon discharge. Collect and report to the Medical Executive Committee 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: Include restorative nursing goals and interventions in residents' care plans, complete required restorative nursing interventions, and document interventions with the frequency established by

facility policy. Ensure documentation reflects resident progress toward goals and reasons why interventions were not provided. Require that employees who perform restorative nursing services receive training on and competency assessment for range of motion.

Magnetic Resonance Imaging Safety: Ensure secondary patient safety screenings are completed and are signed and dated by Level 2 magnetic resonance imaging personnel prior to the scan. Revise local policy to correct contradictory elements and to be consistent with Veterans Health Administration policy.

Construction Safety: Conduct tuberculosis risk assessments. Conduct construction site inspections at the required frequency, and ensure they include all required elements. Conduct and document infection surveillance activities related to construction projects. Ensure that follow-up actions in response to unsafe conditions identified during inspections are documented in Construction Safety Committee minutes and that minutes track actions to completion. Require that all construction projects comply with Veterans Health Administration policy requirements.

Comments

The Acting 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 24–35, for the full text of the Directors' comments.) We consider recommendation 16 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
- Medication Management
- Coordination of Care
- Acute Ischemic Stroke Care
- CLC Resident Independence and Dignity
- MRI Safety
- Construction Safety

We have listed the general information reviewed for each of these activities. Some of the items listed may not have been applicable to this facility because of a difference in size, function, or frequency of occurrence.

The review covered facility operations for FY 2013 and FY 2014 through July 21 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 Long Beach Healthcare System, Long Beach, California,* Report No. 12-02189-14, October 17, 2012).

During this review, we presented crime awareness briefings for 290 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 1,046 responded. We shared summarized results with facility managers.

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

Reported Accomplishments

Bed Management Solution System

In early 2014, to improve inpatient flow, the facility implemented the bed management solution system to alert EMS of beds in need of cleaning. This system updates the status of beds in near real time so the facility bed coordinator can assign patients to beds as they become available. With this system, EMS supervisors are able to better manage and track timeliness of bed cleaning. In addition, the system has fostered a greater level of cooperation between nursing and EMS employees through joint rounds to determine daily demand for services. This allows EMS to adjust staffing to meet clinical needs while improving patient access to inpatient services. Full implementation of the system has reduced bed cleaning turnaround time from 10.8 hours to 3.7 hours.

Outpatient Pharmacy Dispensing Project

In early FY 2013, the facility instituted a systems redesign project to reduce wait times for patients picking up medication at the outpatient pharmacy. The pharmacy introduced a simplified single ticket type waiting system that displays patient names on an overhead screen when medications are ready to be picked up. Additionally, the pharmacy implemented a flexible staffing system that deploys more pharmacists into the patient service area when wait times exceed the goal of 15 minutes. Prior to this project, the pharmacy had a waiting system that frustrated patients and took up to 45 minutes to dispense medication. The redesigned system has reduced pharmacy wait times from 45 minutes to an average of 14 minutes.

Evidence-Based HF Management Initiative

In November 2013, to improve patient outcomes and increase access to inpatient services, the facility implemented an initiative to help identify patients at the highest risk for HF. The team employed evidence-based NCM standards of care and American College of Cardiology clinical practice guidelines. New HF management protocols were instituted, including NCM face-to-face visits during hospitalization, a telephone nursing assessment 48 hours post discharge, a face-to-face visit with the NCM and provider 7-days post discharge, and weekly NCM telephone assessments for 30-days post discharge. The initiative has reduced the facility's HF readmission rate from 33 percent to a current average of 17 percent.

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.	
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.	Eleven months of Resuscitation Services Committee meeting minutes reviewed: • There was no evidence that the committee reviewed each episode. • There was no evidence that code reviews included screening for clinical issues prior to code that may have contributed to the occurrence of the code.
	The surgical review process met selected requirements: • An interdisciplinary committee with appropriate leadership and clinical membership met monthly to review surgical processes and outcomes. • Surgical deaths with identified problems or opportunities for improvement were reviewed. • Additional data elements were routinely reviewed.	
	Critical incidents reporting processes were appropriate.	
	The process to review the quality of entries in the EHR met selected requirements: • A committee was responsible to review EHR quality. • Data were collected and analyzed at least quarterly. • Reviews included data from most services and program areas.	
	The policy for scanning non-VA care documents met selected requirements.	

NM	Areas Reviewed (continued)	Findings
	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 processes be strengthened to ensure that the Resuscitation Services Committee reviews each code episode and that code reviews include screening for clinical issues prior to the code that may have contributed to the occurrence of the code.

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 intensive care, one MH, two spinal cord injury, two CLC, and two medical surgical inpatient units. We also inspected the primary care and eye clinics, the emergency department, SDS, and the PACU. Additionally, we reviewed relevant documents, conversed with key employees and managers, and reviewed 21 employee training records (6 SDS, 10 PACU, and 5 eye clinic). The table below shows the areas reviewed for this topic. The areas marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

NM	Areas Reviewed for General EOC	Findings
X	EOC Committee minutes reflected sufficient detail regarding identified deficiencies, corrective actions taken, and tracking of corrective actions to closure.	Six months of EOC Committee meeting minutes and the EOC rounds database reviewed: • Minutes and the database did not accurately reflect whether deficiencies were resolved.
	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.	• Seven patient care areas and public restrooms in two of the adjoining areas had offensive odors and/or dirty floors, furnishings, walls, and/or window sills. • Three patient care areas had unsealed wall penetrations or damaged counters. • Six patient care areas had equipment items with missing and/or outdated preventive maintenance or electrical safety check stickers. • Three patient care areas had missing, broken, and/or cracked floor tiles. • Three patient care areas had wheelchairs that were damaged or repaired with medical tape.
X	Infection prevention requirements were met.	• In three patient care areas, clean and dirty items were not stored separately.
X	Medication safety and security requirements were met.	• One patient care area had an unsecured medication room door, and one patient care area had expired medications.

NM	Areas Reviewed for General EOC (continued)	Findings
	Auditory privacy requirements were met.	
	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.	
	Areas Reviewed for SDS and the PACU	
	Designated SDS and PACU employees received bloodborne pathogens training during the past 12 months.	
NA	Designated SDS employees received medical laser safety training with the frequency required by local policy.	
	Fire safety requirements in SDS and on the PACU were met.	
	Environmental safety requirements in SDS and on the PACU were met.	
NA	SDS medical laser safety requirements were met.	
	Infection prevention requirements in SDS and on the PACU were met.	
X	Medication safety and security requirements in SDS and on the PACU were met.	• SDS had an open and undated multi-dose vial.
	Auditory privacy requirements in SDS and on the PACU were met.	
	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.	
	Areas Reviewed for Eye Clinic	
	Designated eye clinic employees received laser safety training with the frequency required by local policy.	
X	Environmental safety requirements in the eye clinic were met.	• Two procedure rooms had dirty floors. • Three procedure rooms had unsealed wall penetrations.
	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

2. We recommended that processes be strengthened to ensure that Environment of Care Committee minutes and the environment of care rounds database accurately reflect whether deficiencies were resolved.

3. We recommended that processes be strengthened to ensure that patient care areas and public restrooms are clean and free from offensive odors and walls, counters, floors, and furnishings in these areas are in good repair and that compliance be monitored.

4. We recommended that processes be strengthened to ensure that equipment items receive appropriate maintenance and preventive maintenance and electrical inspections stickers are current and that compliance be monitored.

5. We recommended that processes be strengthened to ensure that clean and dirty items are stored separately and that compliance be monitored.

6. We recommended that processes be strengthened to ensure that expired medications are promptly removed from patient care areas and medications are secured at all times and that compliance be monitored.

Medication Management

The purpose of this review was to determine whether the appropriate clinical oversight and education were provided to patients discharged with orders for fluoroquinolone oral antibiotics.[c]

We reviewed relevant documents and conversed with key managers and employees. Additionally, we reviewed the EHRs of 32 randomly selected inpatients discharged on 1 of 3 selected oral antibiotics. The table below shows the areas reviewed for this topic. The 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	Clinicians conducted inpatient learning assessments within 24 hours of admission or earlier if required by local policy.	• For 5 patients (16 percent), learning assessments were conducted more than 24 hours after admission.
X	If learning barriers were identified as part of the learning assessment, medication counseling was adjusted to accommodate the barrier(s).	• For two of the six patients with identified learning barriers, EHR documentation did not reflect medication counseling accommodation to address the barriers.
	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.	

Recommendations

7. We recommended that processes be strengthened to ensure that patient learning assessments are documented within 24 hours of admission and that compliance be monitored.

8. We recommended that processes be strengthened to ensure that clinicians conducting medication education accommodate identified learning barriers and document the accommodations made to address those barriers and that compliance be monitored.

Coordination of Care

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

We reviewed relevant documents and conversed with key employees. Additionally, we reviewed the EHRs of 29 randomly selected patients with specific diagnoses who were discharged from July 1, 2012, through June 30, 2013. The table below shows the areas reviewed for this topic. Any items that did not apply to this facility are marked NA. The facility generally met requirements. We made no recommendations.

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

Acute Ischemic Stroke Care

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

We reviewed relevant documents, the EHRs of 41 randomly selected patients who experienced stroke symptoms, and 15 employee training records (8 emergency department and 7 intensive care unit), and we conversed with key employees. We also conducted onsite inspections of the emergency department, one intensive care unit, and four acute inpatient units (medical/surgical oncology, direct observation, surgical, and telemetry). The table below shows the areas reviewed for this topic. The areas marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

NM	Areas Reviewed	Findings
	The facility's stroke policy/plan/guideline addressed all required items.	
X	Clinicians completed the National Institutes of Health stroke scale for each patient within the expected timeframe.	• Twenty of the 25 applicable EHRs did not contain documented evidence of completed stroke scales.
	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.	• Twenty-one of the 36 applicable EHRs (58 percent) 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.	• Seven of the 22 applicable EHRs did not contain 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/or reported to the MEC: 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

9. 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.

10. We recommended that processes be strengthened to ensure that clinicians screen patients for difficulty swallowing prior to oral intake and provide patients with printed stroke education upon discharge and that compliance be monitored.

11. We recommended that the facility collect and report to the Medical Executive Committee 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 reviewed 10 EHRs of residents (4 residents receiving restorative nursing services and 6 residents not receiving restorative nursing services but candidates for services). We also observed two meal periods, reviewed nine employee training/competency records and other relevant documents, and conversed with key employees. The table below shows the areas reviewed for this topic. The areas marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

NM	Areas Reviewed	Findings
	The facility offered restorative nursing services.	
X	Facility staff completed and documented restorative nursing services, including active and passive range of motion, bed mobility, transfer, and walking activities, according to clinician orders and residents' care plans.	• In three of the four applicable EHRs, there was no documentation that facility staff included restorative nursing goals and interventions in residents' care plans. • For the one resident with restorative nursing goals and interventions, the EHR did not contain evidence that staff consistently completed required interventions or documented the interventions that were provided with the frequency established by facility policy.
X	Resident progress towards restorative nursing goals was documented, and interventions were modified as needed to promote the resident's accomplishment of goals.	• For the one resident with restorative nursing goals and interventions, the EHR did not contain evidence that facility staff documented resident progress toward goals.
X	When restorative nursing services were care planned but were not provided or were discontinued, reasons were documented in the EHR.	• For the one resident with restorative nursing goals and interventions, when restorative nursing services were not provided, the EHR did not reflect the reasons.
	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.	
X	Training and competency assessment were completed for staff who performed restorative nursing services.	• Two employee training/competency records did not contain evidence of completed training and competency assessment for range of motion.

NM	Areas Reviewed (continued)	Findings
	The facility complied with any additional elements required by VHA or local policy.	
	Areas Reviewed for Assistive Eating Devices and Dining Service	
NA	Care planned/ordered assistive eating devices were provided to residents at meal times.	
	Required activities were performed during resident meal periods.	
	The facility complied with any additional elements required by VHA or local policy.	

Recommendations

12. We recommended that processes be strengthened to ensure that staff include restorative nursing goals and interventions in residents' care plans and that compliance be monitored.

13. We recommended that processes be strengthened to ensure that staff complete required restorative nursing interventions and document the interventions with the frequency established by facility policy, that documentation reflects progress toward goals and reasons why interventions were not provided, and that compliance be monitored.

14. We recommended that processes be strengthened to ensure that employees who perform restorative nursing services receive training on and competency assessment for range of motion.

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 43 employees (28 randomly selected Level 1 ancillary staff and 15 designated Level 2 MRI personnel), and we conversed with key managers and employees. We also reviewed the EHRs of 33 randomly selected patients who had an MRI January 1–December 31, 2013. Additionally, we conducted a physical inspection of the MRI suite. 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 completed an MRI risk assessment, there were documented procedures for handling emergencies in MRI, and emergency drills were 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.	• Secondary patient safety screening forms for six patients (18 percent) were missing or were not signed and/or not dated by Level 2 MRI personnel prior to MRI.
	Any MRI contraindications were noted on the secondary patient safety screening form, and a Level 2 MRI personnel and/or radiologist addressed the contraindications and documented resolution prior to MRI.	
	Level 1 ancillary staff and Level 2 MRI personnel were designated and received level-specific annual MRI safety training.	
	Signage and barriers were in place to prevent unauthorized or accidental access to Zones III and IV.	
	MRI technologists maintained visual contact with patients in the magnet room and two-way communication with patients inside the magnet, and the two-way communication device was regularly tested.	
	Patients were offered MRI-safe hearing protection for use during the scan.	
	The facility had only MRI-safe or compatible equipment in Zones III and IV, or the equipment was appropriately protected from the magnet.	

NM	Areas Reviewed (continued)	Findings
X	The facility complied with any additional elements required by VHA or local policy.	Facility policy on MRI safety and VHA policy reviewed: • The newly published facility policy had contradictory critical elements and was not consistent with VHA policy.

Recommendations

15. We recommended that processes be strengthened to ensure that secondary patient safety screenings are completed immediately prior to magnetic resonance imaging and are signed and dated by a Level 2 magnetic resonance imaging personnel prior to the scan and that compliance be monitored.

16. We recommended that facility policy be revised to correct contradictory elements and to be consistent with VHA policy.

Construction Safety

The purpose of this review was to determine whether the facility maintained infection control and safety precautions during construction and renovation activities in accordance with applicable standards.[h]

We inspected the project to relocate physical therapy and kinesiotherapy from Building 150 first floor to T27 and R4. Additionally, we reviewed relevant documents and 25 training records (6 contractor records and 19 employee records), and we conversed with key employees and managers. 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 multidisciplinary committee to oversee infection control and safety precautions during construction and renovation activities and a policy outlining the responsibilities of the committee, and the committee included all required members.	
X	Infection control, preconstruction, interim life safety, and contractor tuberculosis risk assessments were conducted prior to project initiation.	• Tuberculosis risk assessments were not conducted to determine the risk of tuberculosis transmission to contractors.
	There was documentation of results of contractor tuberculosis skin testing and of follow-up on any positive results.	
	There was a policy addressing Interim Life Safety Measures, and required Interim Life Safety Measures were documented.	
X	Site inspections were conducted by the required multidisciplinary team members at the specified frequency and included all required elements.	Site inspection documentation reviewed. • There was no evidence of the weekly inspections required by VHA and local policy. • There was inconsistent documentation of required elements.
X	Infection Control Committee minutes documented infection surveillance activities associated with the project(s) and any interventions.	Infection Control Committee minutes for past 2 quarters reviewed: • There was no documentation of infection surveillance activities related to the project.
X	Construction Safety Committee minutes documented any unsafe conditions found during inspections and any follow-up actions and tracked actions to completion.	Construction Safety Committee minutes for past 2 quarters reviewed: • For three of six inspections, there was no documented evidence of follow-up actions in the minutes when an unsafe condition was identified.
	Contractors and designated employees received required training.	
	Dust control requirements were met.	

NM	Areas Reviewed (continued)	Findings
	Fire and life safety requirements were met.	
	Hazardous chemicals requirements were met.	
	Storage and security requirements were met.	
X	The facility complied with any additional elements required by VHA or local policy or other regulatory standards.	VHA policy reviewed: • Two small active projects did not have infection control risk assessments, and there were no construction signs, sticky mats, or other containment.

Recommendations

17. We recommended that processes be strengthened to ensure that tuberculosis risk assessments are conducted to determine the risk of tuberculosis transmission to contractors.

18. We recommended that processes be strengthened to ensure that construction site inspections are conducted at the required frequency and that inspections contain all elements required by VHA policy.

19. We recommended that processes be strengthened to ensure that infection surveillance activities related to construction projects are conducted and documented in Infection Control Committee minutes.

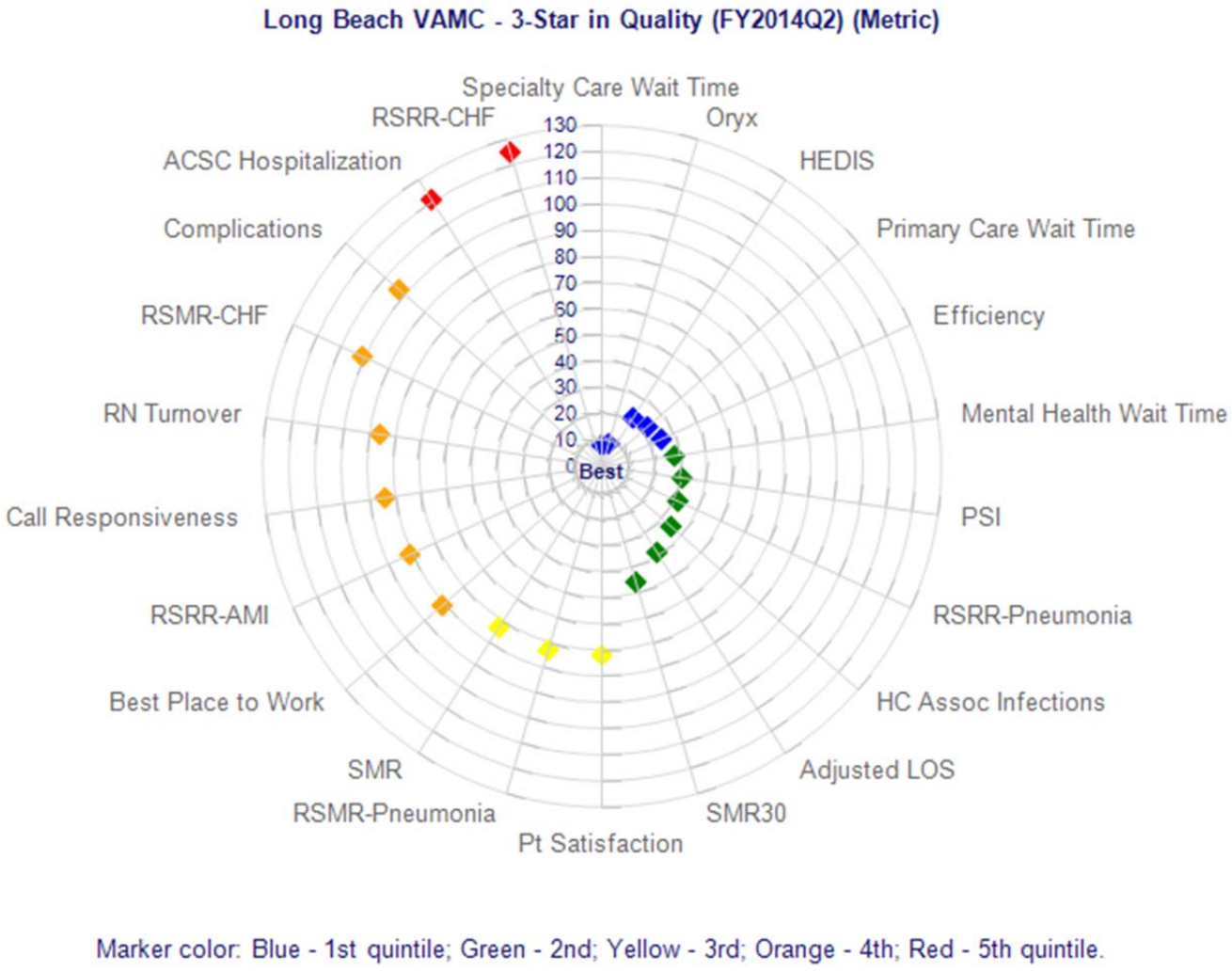
20. We recommended that processes be strengthened to ensure that Construction Safety Committee minutes contain documentation of follow-up actions in response to unsafe conditions identified during inspections and that minutes track actions to completion.

21. We recommended that processes be strengthened to ensure that all construction projects comply with VHA policy requirements.

Facility Profile (Long Beach/600) FY 2014 through June 2014[1]	
Type of Organization	Secondary
Complexity Level	1b-High complexity
Affiliated/Non-Affiliated	Affiliated
Total Medical Care Budget in Millions	$472
Number (as of July 2014) of:	
• **Unique Patients**	50,551
• **Outpatient Visits**	554,979
• **Unique Employees**[2]	1,959
Type and Number of Operating Beds:	
• **Hospital**	304
• **CLC**	110
• **MH**	NA
Average Daily Census:	
• **Hospital**	184
• **CLC**	65
• **MH**	NA
Number of Community Based Outpatient Clinics	5
Location(s)/Station Number(s)	Anaheim/600GA Santa Ana/600GB Cabrillo/600GC Santa Fe Springs-Whittier/600GD Laguna Hills/600GE
VISN Number	22

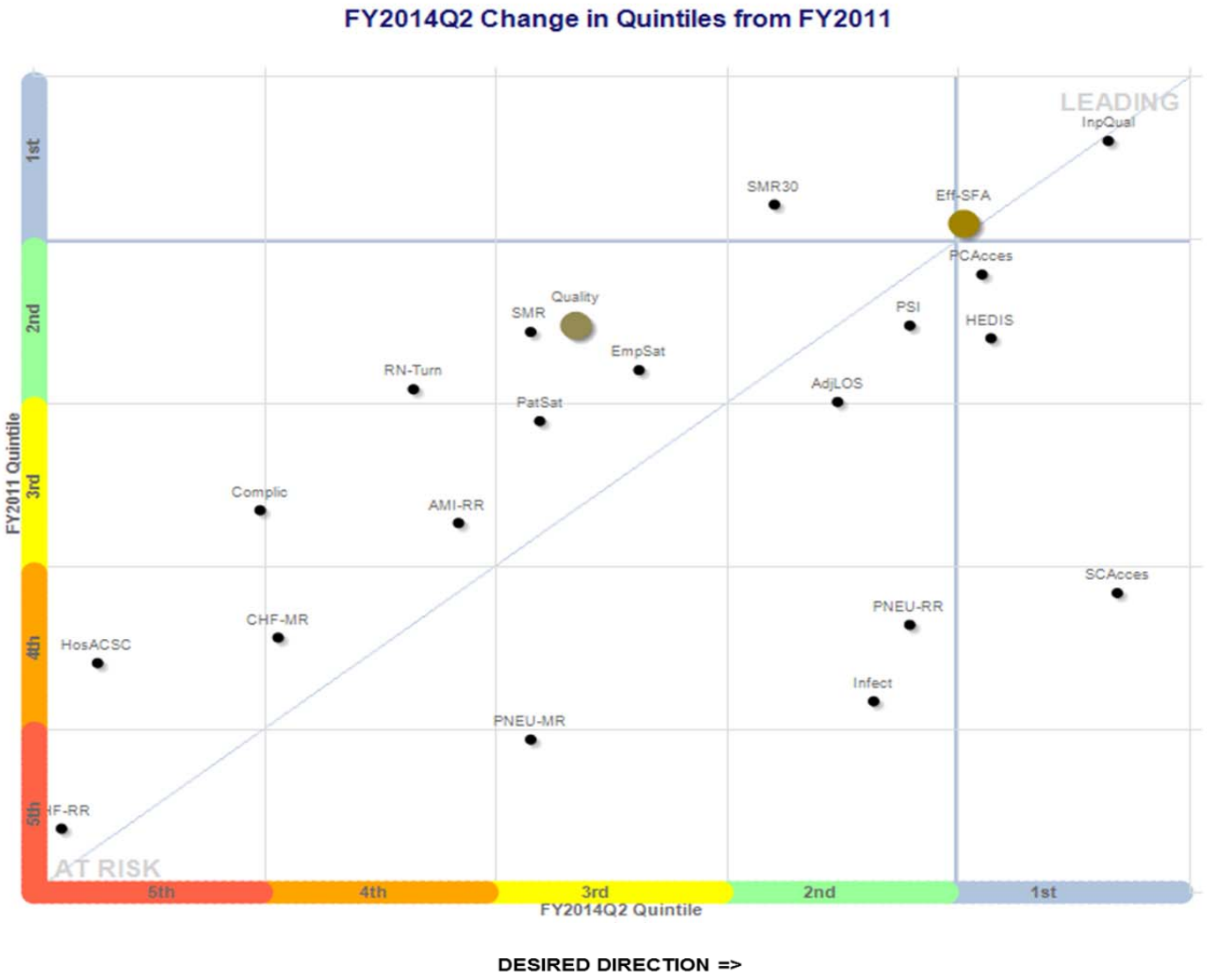
[1] All data is for FY 2014 through June 2014 except where noted.
[2] Unique employees involved in direct medical care (cost center 8200).

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



[c] Metric definitions follow the graphs.

Scatter Chart



NOTE

Quintiles are derived from facility ranking on z-score of a metric among 128 facilities. Lower quintile is more favorable.

Metric Definitions

Measure	Definition	Desired direction
ACSC Hospitalization	Ambulatory care sensitive condition hospitalizations (observed to expected ratio)	A lower value is better than a higher value
Adjusted LOS	Acute care risk adjusted length of stay	A lower value is better than a higher value
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 HF	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 HF	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

Acting VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: September 25, 2014

From: Acting Network Director, VA Desert Pacific Healthcare Network (10N22)

Subject: **Combined Assessment Program (CAP) Review of the VA Long Beach Healthcare System, Long Beach, CA**

To: Director, Operations Division, Office of Management and Administration (53B)

1. I concur with the findings and recommendations in the Combined Assessment Program Review of the VA Long Beach Healthcare System, Long Beach, California, open recommendations 1–21.

2. If you have any questions regarding our response and actions to the recommendations in the draft report, please contact me at (562) 826-5963.

Jeanine Bates, VISN 22 QMO

Jeffrey T. Gering, FACHE

for

Attachment

Facility Director Comments

Department of Veterans Affairs **Memorandum**

Date: September 9, 2014

From: Director, VA Long Beach Healthcare System (600/00)

Subject: **Combined Assessment Program (CAP) Review of the VA Long Beach Healthcare System, Long Beach, CA**

To: Director, VA Desert Pacific Healthcare Network (10N22)

1. Please find attached response to the VA Office of Inspector General's (OIG) CAP Review of the VA Long Beach Healthcare System conducted the week of July 21, 2014.

2. We concur with all recommendations.

Michael W. Fisher

Attachment

Comments to OIG 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 Resuscitation Services Committee reviews each code episode and that code reviews include screening for clinical issues prior to the code that may have contributed to the occurrence of the code.

Concur

Target date for completion: October 2014 and on-going.

Facility response: Resuscitation Services Committee (RSC) members have been instructed to review each code episode prior to meeting, emphasizing the importance of being prepared to discuss clinical issues that may have contributed to the occurrence of the code. All codes will be included in the aggregate and each code episode will be recorded in a database that is available to the committee for their review. Screening for clinical issues prior to codes is conducted, analyzed, and documented in the committee's minutes. The RSC will review the code critique form to identify issues or trends occurring during the code and implement action plans based upon the clinical review.

The aggregate outcomes will be reported to the Medical Executive Committee (MEC) monthly, starting October 2014.

Recommendation 2. We recommended that processes be strengthened to ensure that Environment of Care Committee minutes and the environment of care rounds database accurately reflect whether deficiencies were resolved.

Concur

Target date for completion: October 2014 and on-going.

Facility response: Monthly Environment, Safety, and Health Leadership Council (ESHLC) minutes include a standing Environment of Care (EOC) Deficiency Audit agenda item. Field sampling audits representing no less than 25 percent of resolved deficiencies are conducted monthly by trained staff. The audit verifies if the deficiency was completed and closed and calculates a monthly percentage of accuracy. Audit results are reported monthly to the ESHLC.

Monthly EOC Deficiency Audit results are sustained at greater-than-or-equal-to 90 percent.

Recommendation 3. We recommended that processes be strengthened to ensure that patient care areas and public restrooms are clean and free from offensive odors and walls, counters, floors, and furnishings in these areas are in good repair and that compliance be monitored.

Concur

Target date for completion: October 2014 and ongoing.

Facility response: In addition to daily cleaning, all inpatient rooms and bathrooms will be deep cleaned (clean ceiling and vents, wash walls, clean sinks and commodes, clean corners, scrub floor) once a week. A daily cleaning schedule will be implemented, and monitored by EMS supervisors for completeness and compliance of cleaning.

Supervisory staff conducts weekly audits utilizing an inspection tool which will be analyzed, tracked, and trended for compliance. A measure for offensive odors will be added to the audit tool.

Audit results reported monthly to ESHLC. Monthly EMS Audit results are sustained at greater-than-or-equal-to 90 percent.

Evaluating the condition of furnishings is conducted during weekly EOC Rounds as part of the EOC National Checklist and is also evaluated by the Supervisor of the area/unit monthly. The EOC checklist is maintained and data is tracked, trended and analyzed and presented to the ESHLC and included in the Environmental Management Service (EMS) dashboard. Furnishings not in compliance are immediately taken out of service by tagging the item, removing the item, and reporting it to the area supervisor. If item is available, it will be replaced immediately; if not a purchase order will be submitted for replacement.

Monthly compliance is represented by percentage of deficiencies compared to the number of unique service locations. Compliance is evidenced when measure of success is equal or greater than 90 percent.

Recommendation 4. We recommended that processes be strengthened to ensure that equipment items receive appropriate maintenance and preventive maintenance and electrical inspections stickers are current and that compliance be monitored.

Concur

Target date for completion: April 2015.

Facility response: It has been identified that equipment that does not require preventative maintenance, were tagged with preventative maintenance stickers. To ensure that the preventative maintenance and electrical inspection processes are strengthened, a new “no Preventative Maintenance required” inspection sticker will be deployed on equipment that is identified as low risk per Medical Equipment Management Plan.

Equipment that requires preventative maintenance will be monitored using the VISTA work order system, to ensure that 90 percent or greater of all equipment that requires preventative maintenance is completed within the month that the equipment is scheduled for maintenance.

Educate staff on how to identify out-of-date inspection stickers, and the process for notifying Engineering of equipment out of compliance. In-services will be conducted in each ward and clinical area. Compliance will be reported monthly to ESHLC until compliance is equal or greater than 90 percent.

Recommendation 5. We recommended that processes be strengthened to ensure that clean and dirty items are stored separately and that compliance be monitored.

Concur

Target date for completion: October 2014 and on-going.

Facility response: The VA Long Beach Healthcare System Policy concerning the separation of clean and dirty items in patient care areas will be reviewed with all nursing and EMS employees that work in clinical areas where these items are stored. Staff meetings will be conducted to emphasize the importance of adhering to infection control principles and guidelines to maintain patient safety. Unit managers and supervisors will conduct ongoing and random observations with on the spot corrective actions and additional staff education as needed. Repeat offenses by employees will be addressed through counseling and progressive disciplinary actions.

Compliance is evaluated through EOC Rounds of patient care areas. Deficiencies are tracked and trended using Performance Logic software. Audit results are reported monthly to the ESHLC.

The measure of success is compliance at 90 percent or greater.

Recommendation 6. We recommended that processes be strengthened to ensure that expired medications are promptly removed from patient care areas and medications are secured at all times and that compliance be monitored.

Concur

Target date for completion: October 2014 and ongoing.

Facility response: The Healthcare System Policy concerning medication management and storage will be reviewed with all nursing and pharmacy employees that work in clinical areas where medications are stored. The respective supervisors will emphasize the roles and expectations of staff regarding secure storage of medications and the removal of expired medications.

Nursing and pharmacy will make routine rounds to monitor compliance with the established Healthcare System Policy. Identified deficiencies will be corrected on the

spot and reviewed with staff to determine factors that may contribute to non-compliance. Nursing and pharmacy leadership will collaborate when opportunities for improvement are identified.

Oversight will be provided by the Organizational Excellence Board through reporting of deficiencies from weekly EOC rounds/inspections using performance logic software, with a goal that 90 percent of rounds in clinical areas do not result in deficiencies.

Recommendation 7. We recommended that processes be strengthened to ensure that patient learning assessments are documented within 24 hours of admission and that compliance be monitored.

Concur

Target date for completion: November 2015 and on-going.

Facility response: The current nursing admission note allows nurses to bypass the patient education section, which includes the patient learning assessment. It is important to note that nurses are consistently completing this assessment; however, they are not doing so at the time of admission. Veteran Affairs Long Beach Healthcare System (VALBHS) is consulting with the Clinical Application Coordinators and the Office of Information and Technology to explore the possibility of creating a note template that will require nurses to complete the patient learning assessment (mandatory fields) prior to signing the note. In the meantime, nurses are being educated and reminded to complete this assessment on all patients within the 24-hour timeframe. Nurse Managers will emphasize the importance of this assessment and assess for barriers that impede compliance.

Monthly random audits of at least 30 medical records will be conducted by nursing managers to monitor compliance of the learning assessment requirement. Results will be reported monthly to the Organizational Excellence Board until 90 percent or greater compliance is achieved.

Recommendation 8. We recommended that processes be strengthened to ensure that clinicians conducting medication education accommodate identified learning barriers and document the accommodations made to address those barriers and that compliance be monitored.

Concur

Target date for completion: October 2014 and on-going.

Facility response: The pharmacy counselling discharge note and nursing discharge note will be updated to include documentation of how learning barriers have been accommodated. VALBHS is consulting with the Clinical Application Coordinators and the Office of Information and Technology to explore the possibility of making these fields mandatory.

All nursing and pharmacy staff will be educated on the updated changes to the discharge notes. Monthly random audits of at least 30 medical records will be conducted by Quality Management to monitor compliance with the requirement. Results will be reported to the OEB monthly until a measure of success of 90 percent or great is sustained.

Recommendation 9. 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: October 2014 and ongoing.

Facility response: Medicine leadership is providing additional education, monitoring, and oversight to ensure that clinicians complete the National Institutes of Health Stroke Scale (NIHSS) template in CPRS for each patient presenting with stroke symptoms.

The Emergency Department will monitor completion of the NIHSS template through 100 percent chart audits monthly. The measure of success will be 90 percent or greater. Audit results will be reported to the MEC.

Recommendation 10. We recommended that processes be strengthened to ensure that clinicians screen patients for difficulty swallowing prior to oral intake and that patients are provided with printed stroke education upon discharge and that compliance be monitored.

Concur

Target date for completion: October 2014.

Facility response: Dysphagia screening has been added to the Acute Ischemic Stroke (AIS) template in CPRS. All clinicians have been educated and reminded to complete the screening on every patient presenting with stroke symptoms, with an emphasis on not providing any oral intake until the screening is completed and it is confirmed that the patient does not have swallowing difficulties.

In addition, clinicians provide stroke patients and their families/caregivers educational stroke handouts upon discharge. The patient/family education is documented in CPRS.

The Emergency Department staff champions complete the dysphasia screening on the AIS template, which will be compared with documentation of oral intake. All patient charts will be audited for compliance when dysphagia is associated with AIS. The results of dysphagia screening will be reported to MEC and OEB.

Ongoing monthly chart audits will be conducted until three (3) consecutive months of 90 percent compliance rate is achieved.

Recommendation 11. We recommended that the facility collect and report to the Medical Executive Committee 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 2014 and ongoing.

Facility response: 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 will be monitored through chart audits and reported monthly to MEC.

In addition, the data collected in chart audits will be reviewed, analyzed, and aggregated by the Stroke Committee to identify opportunities for improvement and to strengthen processes.

Recommendation 12. We recommended that processes be strengthened to ensure that staff include restorative nursing goals and interventions in residents' care plans and that compliance be monitored.

Concur

Target date for completion: October 2014 and ongoing.

Facility response: All residents that receive restorative nursing services will have goals and interventions included in their overall plan of care. These goals will be discussed and analyzed at the monthly interdisciplinary team meetings. The plan of care is updated at least quarterly or more frequently if there is a change in condition or services.

The Nurse Managers will audit all care plans for patients receiving restorative care monthly to ensure that restorative care goals are current and accurate.

Ongoing monthly chart audits will be conducted until three (3) consecutive months of 90 percent compliance rate is achieved.

Recommendation 13. We recommended that processes be strengthened to ensure that staff complete required restorative nursing interventions and document the interventions with the frequency established by facility policy, that documentation reflects progress toward goals and reasons why interventions were not provided, and that compliance be monitored.

Concur

Target date for completion: October 2014 and ongoing.

Facility response: Community Living Center (CLC) leadership is providing additional monitoring and oversight to ensure that timely, accurate, and complete documentation of nursing interventions for restorative care are in accordance with the local CLC Restorative Care policy. Nurse Managers will audit documentation monthly.

CLC leadership is also providing additional education and monitoring to ensure that the CLC RN weekly summary note in CPRS includes the resident's progress toward their restorative goals, as indicated in the care plan. Nurse Managers will audit documentation monthly to ensure that they are accurate, compliant, and complete.

The results of the audits will be discussed and analyzed at the monthly CLC leadership meeting. Action plans will be developed based on the analyses of the audits and opportunities for improvement.

Recommendation 14. We recommended that processes be strengthened to ensure that employees who perform restorative nursing services receive training on and competency assessment for range of motion.

Concur

Target date for completion: October 2014 and ongoing.

Facility response: At time of survey, the CLC staff training and competencies regarding Restorative Nursing Care were completed and maintained as a collaborative effort between the Restorative Nurse and the Nurse Manager; however, this led to confusion and deficiencies. A more efficient process has been implemented with sole responsibility and oversight by the respective Nurse Manager of each ward. In addition, the nurse managers have designated a smaller pool of staff that are responsible for these functions so that more intensive training, attention, and oversight can be provided, as it relates to training and competency requirements. The Nurse Managers will be held accountable for ensuring that all staff assigned to perform range of motion (ROM) and other restorative nursing care maintain training and competency skills assessments. Their learning needs will be assessed annually, and ongoing, with on-the-spot training and/or formal training, as needed. All current CLC staff performing restorative care has completed competency assessments and new staff assigned to perform restorative care will have their training and competency assessments completed during initial orientation.

Recommendation 15. We recommended that processes be strengthened to ensure that secondary patient safety screenings are completed immediately prior to magnetic resonance imaging and are signed and dated by a Level 2 magnetic resonance imaging personnel prior to the scan and that compliance be monitored.

Concur

Target date for completion: January 2015 and ongoing.

Facility response: The present patient safety screening template is being revised to include an additional signature/date line for the technician completing the secondary safety screening. Daily audits of the Magnetic Resonance Imaging (MRI) secondary screening forms will be conducted by the supervisor to ensure that the form is accurate and complete, and that screening is performed immediately prior to the MRI procedure. All MRI's are reviewed to confirm that the secondary safety screenings have been scanned into PACS/CPRS.

The data will be tracked, trended, and reported on a monthly basis to the Radiology Quality Committee and Chief of Quality Management. Monitoring will continue until compliance of 90 percent or greater is achieved and sustained.

Recommendation 16. We recommended that facility policy be revised to correct contradictory elements and to be consistent with VHA policy.

Concur

Target date for completion: October 2014.

Facility response: The MRI Safety policy was revised to be consistent with VHA policy. It was reviewed by the MRI Safety Committee and approved by the Radiology MRI Section leadership.

Recommendation 17. We recommended that processes be strengthened to ensure that tuberculosis risk assessments are conducted to determine the risk of tuberculosis transmission to contractors.

Concur

Target date for completion: October 2014 and on-going.

Facility response: A Construction Safety TB Risk Assessment tool is being developed by the Infection Control Preventionist, in collaboration with the Chair and Co-Chair of the Construction Safety Committee (CSC). The tool will be incorporated into the existing pre-Construction Risk Assessment tool currently in use. The risk assessment tool will be based upon contractor's proximity to high risk patients and coordinated with Infection Control's facility-wide TB risk assessment. The risk assessment will minimize the risk of TB transmission to contractors. Training will be provided to all Construction Safety Officers on the proper use of the tool and the importance of its implementation. Training on the TB Risk Assessment tool will be ongoing with first training session scheduled for September 2014.

Monitoring of compliance will be performed by the CSC, with a target that 100 percent of construction contractors will have a TB pre-construction risk assessment. Risk assessment compliance will be presented monthly to the ESHLC, for ongoing oversight.

Recommendation 18. We recommended that processes be strengthened to ensure that construction site inspections are conducted at the required frequency and that inspections contain all elements required by VHA policy.

Concur

Target date for completion: October 2014 and ongoing.

Facility response: Construction inspection folders in use by Construction Safety Officers have been updated to include all inspection elements required by VHA policy. The CSC Charter is updated to address the specific frequency of construction inspections by the Construction Safety Committee. Weekly inspections will be conducted, consistent with VHA Directive 2011-036 and VA Long Beach Policy 138-03, scheduled through the electronic work order system.

Weekly inspections will be tracked and analyzed using the CSC dashboard with a targeted compliance of 100 percent for all construction.

Construction inspection compliance is reported to the Environment Safety Health and Leadership Counsel monthly for ongoing oversight.

Recommendation 19. We recommended that processes be strengthened to ensure that infection surveillance activities related to construction projects are conducted and documented in Infection Control Committee minutes.

Concur

Target date for completion: October 2014 and ongoing.

Facility response: Infection surveillance activities occur daily and are conducted by the Construction Safety Officer. Infection surveillance results are forwarded to the Infection Control Preventionist and documented in the minutes of both the Infection Control Committee (ICC) and Construction Safety Committee (CSC).

Infection surveillance activities are tracked on the ICC dashboard. Compliance is reported to the Environment Safety Health and Leadership Counsel monthly.

Recommendation 20. We recommended that processes be strengthened to ensure that Construction Safety Committee minutes contain documentation of follow-up actions in response to unsafe conditions identified during inspections and that minutes track actions to completion.

Concur

Target date for completion: October 2014 and ongoing.

Facility response: CSC meeting minutes will include all identified unsafe conditions with related follow-up actions that need to be tracked, to ensure deficiencies are corrected.

All CSC Inspectors and the Construction Safety Officers (CSO's) will use the CEOSH Construction Safety Inspection form, which includes a mechanism to track the close-out of deficiencies.

Monitoring will occur using the CSC dashboard that will track completion level. Results will be reported to the ESHLC monthly.

Recommendation 21. We recommended that processes be strengthened to ensure that all construction projects comply with VHA policy requirements.

Concur

Target date for completion: October 2014 and ongoing.

Facility response: The Construction Safety Committee (CSC) will strengthen its processes by extending the scope and depth of the program to include all construction activities of the Engineering Shops, Interior Design, and Office of Informatics and Technology. These small jobs have not been previously included in the CSC.

The CSC charter will be updated to specifically address inclusion of these small projects. A dashboard will be developed that will track the weekly updates of the small job construction activity reports and associated weekly inspections, with the target of 100 percent. The CSC Charter update and the new small job construction activities reports will be implemented in October 2014.

Results will be reported to the ESHLC monthly.

OIG Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the OIG at (202) 461-4720.
Onsite Contributors	Yoonhee Kim, PharmD, Team Leader Paula Chapman, CTRS Frank Keslof, MHA Jeanne Martin, PharmD Simonette Reyes, RN Kathleen Shimoda, RN Julie Story, RN Jovie Yabes, RN Brian Kelly, Special Agent, Office of Investigations
Other Contributors	Daisy Arugay, MT Elizabeth Bullock Shirley Carlile, BA Lin Clegg, PhD Marnette Dhooghe, MS Jeff Joppie, BS Nathan McClafferty, MS Jackelinne Melendez, MPA Patrick Smith, M. Stat Julie Watrous, RN, MS Jarvis Yu, MS

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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.
- VHA Handbook 1907.01, *Health Information Management and Health Records*, September 19, 2012.
- VHA Directive 6300, *Records Management*, July 10, 2012.
- VHA Directive 2009-005, *Transfusion Utilization Committee and Program*, February 9, 2009.
- VHA Handbook 1106.01, *Pathology and Laboratory Medicine Service Procedures*, October 6, 2008.

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

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

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

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

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

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

[h] References used for this topic included:
- VHA Directive 2011-036, *Safety and Health During Construction*, September 22, 2011.
- VA Office of Construction and Facilities Management, *Master Construction Specifications*, Div. 1, "Special Sections," Div. 01 00 00, "General Requirements," Sec. 1.5, "Fire Safety."
- Various Centers for Disease Control and Prevention recommendations and guidelines, Joint Commission standards, and Occupational Safety and Health Administration regulations.