Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 14-04214-70

Combined Assessment Program Review of the Gulf Coast Veterans Health Care System Biloxi, Mississippi

January 20, 2015

Washington, DC 20420

To Report Suspected Wrongdoing in VA Programs and Operations
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Glossary

CAP	Combined Assessment Program
CLC	community living center
COC	coordination of care
EAM	emergency airway management
EHR	electronic health record
EOC	environment of care
facility	Gulf Coast Veterans Health Care System
FY	fiscal year
MH	mental health
NA	not applicable
NM	not met
OIG	Office of Inspector General
QM	quality management
RRTP	residential rehabilitation treatment program
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 October 20, 2014.

Review Results: The review covered eight activities and two follow-up review areas from the previous Combined Assessment Program review. We made no recommendations in the following two activities:

- Surgical Complexity
- Mental Health Residential Rehabilitation Treatment Program

Recommendations: We made recommendations in the following six activities and two follow-up review areas:

Quality Management: Review privilege forms annually, and document the review.

Environment of Care: Require that employees receive training on chemical labeling/safety data sheets. Ensure floors in patient care areas are clean. Consult with the manufacturer to resolve the issue of dirty-appearing sinks. Ensure all designated employees receive annual bloodborne pathogens training.

Medication Management: Revise the policy for safe use of automated dispensing machines to include employee training and minimum competency requirements for users. Ensure designated employees receive automated dispensing machine training and competency assessment.

Coordination of Care: Ensure requestors consistently include "inpatient" in the consult title.

Acute Ischemic Stroke Care: Develop and implement an acute ischemic stroke policy that addresses all required items. 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 all required data elements to the Veterans Health Administration.

Emergency Airway Management: Revise the emergency airway management policy to include the availability of videolaryngoscopes for clinician use and a plan for managing a difficult airway. Ensure completion of clinician reassessment for continued emergency airway management competency at the time of renewal of privileges or scope of practice. Require that a clinician with emergency airway management privileges or scope of practice is available during all hours the facility provides patient care.

Follow-Up on Quality Management Issue: Complete at least two preventive ethics improvement cycles each fiscal year.

Follow-Up on Coordination of Care Issue: Consistently schedule follow-up appointments within the timeframes requested by providers.

Comments

The Interim VISN Director and Acting Facility Director agreed with the Combined Assessment Program review findings and recommendations and provided acceptable improvement plans. (See Appendixes C and D, pages 27–35, for the full text of the Directors' comments.) We consider recommendation 9 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 and two follow-up review areas from the previous CAP review:

- QM
- EOC
- Medication Management
- COC
- Acute Ischemic Stroke Care
- Surgical Complexity
- EAM
- MH RRTP
- Follow-Up on QM Issue
- Follow-Up on COC Issue

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, FY 2014, and FY 2015 through October 20, 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 Gulf Coast Veterans Health Care System, Biloxi, Mississippi,* Report No. 11-03668-107, February 29, 2012). We made repeat recommendations in QM and COC.

During this review, we presented crime awareness briefings for 125 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 283 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, one credentialing and privileging folder, 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	Recommendations
	There was a senior-level committee responsible for key quality, safety, and value functions that met at least quarterly and was chaired or co-chaired by the facility Director. • The committee routinely reviewed aggregated data. • QM, patient safety, and systems redesign appeared to be integrated.		
	Peer reviewed deaths met selected requirements: • Peers completed reviews within specified timeframes. • The Peer Review Committee reviewed cases receiving initial Level 2 or 3 ratings. • Involved providers were invited to provide input prior to the final Peer Review Committee determination.		

NM	Areas Reviewed (continued)	Findings	Recommendations
X	Credentialing and privileging processes met selected requirements: • Facility managers reviewed privilege forms annually and ensured proper approval of revised forms. • Facility managers ensured appropriate privileges for licensed independent practitioners. • Facility managers removed licensed independent practitioners' access to patients' EHRs upon separation. • Facility managers properly maintained licensed independent practitioners' folders.	• Facility managers did not review privilege forms annually.	**1.** We recommended that facility managers review privilege forms annually and document the review.
	Observation bed use met selected requirements: • The facility gathered data regarding appropriateness of observation bed usage. • The facility reassessed observation criteria and/or utilization if conversions to acute admissions were consistently 25–30 percent or more.		
	The process to review resuscitation events met selected requirements: • An interdisciplinary committee reviewed 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. • The facility collected data that measured performance in responding to events.		

NM	Areas Reviewed (continued)	Findings	Recommendations
	The surgical review process met selected requirements: • An interdisciplinary committee with appropriate leadership and clinical membership met monthly to review surgical processes and outcomes. • The Surgical Work Group reviewed surgical deaths with identified problems or opportunities for improvement. • The Surgical Work Group reviewed additional data elements.		
	Clinicians appropriately reported critical incidents.		
	The safe patient handling program met selected requirements: • A committee provided program oversight. • The committee gathered, tracked, and shared patient handling injury data.		
	The process to review the quality of entries in the EHR met selected requirements: • A committee reviewed EHR quality. • A committee analyzed data at least quarterly. • Reviews included data from most services and program areas.		
	The policy for scanning internal forms into EHRs included the following required items: • Quality of the source document and an alternative means of capturing data when the quality of the document is inadequate. • A correction process if scanned items have errors.		

NM	Areas Reviewed (continued)	Findings	Recommendations
	• A complete review of scanned documents to ensure readability and retrievability of the record and quality assurance reviews on a sample of the scanned documents.		
	Overall, if QM reviews identified significant issues, the facility took actions and evaluated them for effectiveness.		
	Overall, senior managers actively participated in performance improvement over the past 12 months.		
	Overall, the facility had a comprehensive, effective QM program over the past 12 months.		
	The facility met any additional elements required by VHA or local policy.		

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. We also determined whether the facility met selected requirements in critical care and the CLC.[b]

We inspected the medical/surgical, MH, blind rehabilitation, and critical care units; the emergency department; a primary care clinic; and two units in the CLC. Additionally, we reviewed relevant documents, including inspection documentation for 10 alarm-equipped medical devices in critical care, and 30 employee training records (10 critical care and 20 CLC) and 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 for General EOC	Findings	Recommendations
	EOC Committee minutes reflected sufficient detail regarding identified deficiencies, corrective actions taken, and tracking of corrective actions to closure for the facility and the community based outpatient clinics.		
	The facility conducted an infection prevention risk assessment.		
	Infection Prevention/Control Committee minutes documented discussion of identified high-risk areas, actions implemented to address those areas, and follow-up on implemented actions and included analysis of surveillance activities and data.		
	The facility had established a process for cleaning equipment.		
X	Selected employees received training on updated requirements regarding chemical labeling and safety data sheets.	• Four of the 29 applicable employee training records did not contain evidence of chemical labeling/safety data sheet training.	**2.** We recommended that facility managers ensure employees receive training on chemical labeling/safety data sheets.
	The facility met fire safety requirements.		

NM	Areas Reviewed for General EOC (continued)	Findings	Recommendations
X	The facility met environmental safety requirements.	• The bathroom floors on the locked MH inpatient unit and the treatment room floors in the emergency department were dirty. • Sinks installed throughout the facility during the last 2 years appeared dirty.	**3.** We recommended that facility managers ensure floors in patient care areas are clean and monitor compliance. **4.** We recommended that facility managers consult with the manufacturer regarding the issue of dirty-appearing sinks and take any recommended actions.
	The facility met infection prevention requirements.		
	The facility met medication safety and security requirements.		
	The facility met privacy requirements.		
	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.		
	Areas Reviewed for Critical Care		
X	Designated critical care employees received bloodborne pathogens training during the past 12 months.	• Two of the 10 critical care employees did not receive bloodborne pathogens training during the past 12 months.	**5.** We recommended that facility managers ensure all designated employees receive annual bloodborne pathogens training and monitor compliance.
	Alarm-equipped medical devices used in critical care were inspected/checked according to local policy and/or manufacturers' recommendations.		
	The facility met fire safety requirements in critical care.		
	The facility met environmental safety requirements in critical care.		
	The facility met infection prevention requirements in critical care.		
	The facility met medication safety and security requirements in critical care.		

NM	Areas Reviewed for Critical Care (continued)	Findings	Recommendations
	The facility met medical equipment requirements in critical care.		
	The facility met privacy requirements in critical care.		
	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.		
	Areas Reviewed for CLC		
X	Designated CLC employees received bloodborne pathogens training during the past 12 months.	• Fifteen of the 20 CLC employees did not receive bloodborne pathogens training within the past 12 months.	See recommendation 5.
NA	For CLCs with resident animal programs, the facility conducted infection prevention risk assessments and had policies addressing selected requirements.		
NA	For CLCs with elopement prevention systems, the facility documented functionality checks at least every 24 hours and documented complete system checks annually.		
	The facility met fire safety requirements in the CLC.		
	The facility met environmental safety requirements in the CLC.		
	The facility met infection prevention requirements in the CLC.		
	The facility met medication safety and security requirements in the CLC.		
	The facility met medical equipment requirements in the CLC.		
	The facility met privacy requirements in the CLC.		

NM	Areas Reviewed for CLC (continued)	Findings	Recommendations
	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.		
	Areas Reviewed for Construction Safety		
NA	The facility met selected dust control, temporary barrier, storage, and security requirements for the construction site perimeter.		
NA	The facility complied with any additional elements required by VHA or local policy, or other regulatory standards.		

Medication Management

The purpose of this review was to determine whether the facility had established safe medication storage practices in accordance with VHA policy and Joint Commission standards.[c]

We reviewed relevant documents, the training records of 14 nursing employees, and pharmacy monthly medication storage area inspection documentation for the past 6 months. Additionally, we inspected the intensive care unit, the medical/surgical unit, the post-anesthesia care unit, and the emergency department and for these areas reviewed documentation of narcotic wastage from automated dispensing machines and inspected crash carts containing emergency medications. 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	Recommendations
	Facility policy addressed medication receipt in patient care areas, storage procedures until administration, and staff authorized to have access to medications and areas used to store them.		
	The facility required two signatures on controlled substances partial dose wasting.		
	The facility defined those medications and supplies needed for emergencies and procedures for crash cart checks, checks included all required elements, and the facility conducted checks with the frequency required by local policy.		
	The facility prohibited storage of potassium chloride in patient care areas.		
	If the facility stocked heparin in concentrations of more than 5,000 units per milliliter in patient care areas, the Chief of Pharmacy approved it.		

NM	Areas Reviewed (continued)	Findings	Recommendations
	The facility maintained a list of the look-alike and sound-alike medications it stores, dispenses, and administers; reviewed this list annually and ensured it was available for staff reference; and had labeling/storage processes to prevent errors.		
	The facility identified in writing its high-alert and hazardous medications, ensured the high-alert list was available for staff reference, and had processes to manage these medications.		
	The facility conducted and documented inspections of all medication storage areas at least every 30 days, fully implemented corrective actions, and monitored the changes.		
X	The facility/Pharmacy Service had a written policy for safe use of automated dispensing machines that included oversight of overrides and employee training and minimum competency requirements for users, and employees received training or competency assessment in accordance with local policy.	• Facility policy for safe use of automated dispensing machines did not include employee training or minimum competency requirements for users. • Four nursing employees did not have documentation of automated dispensing machine training and competency assessment.	**6.** We recommended that the facility revise the policy for safe use of automated dispensing machines to include employee training and minimum competency requirements for users and that facility managers monitor compliance. **7.** We recommended that facility managers ensure designated employees receive automated dispensing machine training and competency assessment and monitor compliance.
	The facility employed practices to prevent wrong-route drug errors.		
NA	Medications prepared but not immediately administered contained labels with all required elements.		
NA	The facility removed medications awaiting destruction or stored them separately from medications available for administration.		

NM	Areas Reviewed (continued)	Findings	Recommendations
	The facility met multi-dose insulin pen requirements.		
	The facility complied with any additional elements required by VHA or local policy.		

COC

The purpose of this review was to evaluate the consult management process and the completion of inpatient clinical consults.[d]

We reviewed relevant documents, and we conversed with key employees. Additionally, we reviewed the EHRs of 40 randomly selected patients who had a consult requested during an acute care admission from January 1 through June 30, 2014. The table below shows the areas reviewed for this topic. The area marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

NM	Areas Reviewed	Findings	Recommendations
	A committee oversaw the facility's consult management processes.		
	Major bed services had designated employees to: • Provide training in the use of the computerized consult package • Review and manage consults		
X	Consult requests met selected requirements: • Requestors included the reason for the consult. • Requestors selected the proper consult title. • Consultants appropriately changed consult statuses, linked responses to the requests, and completed consults within the specified timeframe.	• Five consult requests (13 percent) did not include "inpatient" in the title.	**8.** We recommended that requestors consistently include "inpatient" in the consult title and that facility managers monitor compliance.
	The facility met 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 and the EHRs of 26 randomly selected patients who experienced stroke symptoms, and we conversed with key employees. We also conducted onsite inspections of the emergency department, one critical care unit, and one acute inpatient unit. 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	Recommendations
X	The facility's stroke policy addressed all required items.	• The facility did not have a policy in place that addressed the management of acute ischemic stroke.	**9.** We recommended that the facility develop and implement an acute ischemic stroke policy that addresses all required items.
X	Clinicians completed the National Institutes of Health stroke scale for each patient within the expected timeframe.	• For seven of the 19 applicable patients, clinicians did not document evidence of completion of stroke scales.	**10.** We recommended that clinicians complete and document National Institutes of Health stroke scales for each stroke patient and that facility managers monitor compliance.
NA	Clinicians provided medication (tissue plasminogen activator) timely to halt the stroke and included all required steps, and the facility stocked tissue plasminogen activator in appropriate areas.		
	Facility managers posted stroke guidelines 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.	• For four of the eight applicable patients, clinicians did not document in the EHRs that they screened the patients for difficulty swallowing prior to oral intake.	**11.** We recommended that clinicians screen patients for difficulty swallowing prior to oral intake and that facility managers monitor compliance.

NM	Areas Reviewed (continued)	Findings	Recommendations
X	Clinicians provided printed stroke education to patients upon discharge.	• None of the seven applicable patients' EHRs contained documentation that clinicians provided stroke education to the patients/caregivers.	**12.** We recommended that clinicians provide printed stroke education to patients upon discharge and that facility managers monitor compliance.
NA	The facility provided training to employees involved in assessing and treating stroke patients.		
X	The facility collected and reported required data related to stroke care.	• The facility did not collect and/or report the following data to VHA: o Percent of eligible patients given tissue plasminogen activator o Percent of patients with stroke symptoms who had the stroke scale completed o Percent of patients screened for difficulty swallowing before oral intake	**13.** We recommended that the facility collect and report to the Veterans Health Administration 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 facility complied with any additional elements required by VHA or local policy.		

Surgical Complexity

The purpose of this review was to determine whether the facility provided selected support services appropriate to their assigned surgical complexity designation.[f]

We reviewed relevant documents and the training records of 20 employees, and we conversed with key managers and employees. The table below shows the areas reviewed for this topic. Any items that did not apply to this facility are marked NA. The facility generally met requirements. We made no recommendations.

NM	Areas Reviewed	Findings	Recommendations
	Facility policy defined appropriate availability for all support services required by VHA for the facility's surgical designation.		
	Employees providing selected tests and patient care after operational hours had appropriate competency assessments and validation.		
	The facility properly reported surgical procedures performed that were beyond the facility's surgical complexity designation. • The facility reviewed and implemented recommendations made by the VISN Chief Surgical Consultant.		
	The facility complied with any additional elements required by VHA or local policy.		

EAM

The purpose of this review was to determine whether the facility complied with selected VHA out of operating room airway management requirements.[g]

We reviewed relevant documents, including competency assessment documentation of 13 clinicians, and we conversed with key managers and 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	Recommendations
	The facility had a local EAM policy or had a documented exemption.		
NA	If the facility had an exemption, it did not have employees privileged to perform procedures using moderate or deep sedation that might lead to airway compromise.		
	Facility policy designated a clinical subject matter expert, such as the Chief of Staff or Chief of Anesthesia, to oversee EAM.		
X	Facility policy addressed key VHA requirements, including: • Competency assessment and reassessment processes • Use of equipment to confirm proper placement of breathing tubes • A plan for managing a difficult airway	• Facility policy did not address the availability of videolaryngoscopes for use by clinicians or a plan for managing a difficult airway.	**14.** We recommended that the facility revise the emergency airway management policy to include the availability of videolaryngoscopes for use by clinicians and a plan for managing a difficult airway.
	Initial competency assessment for EAM included: • Subject matter content elements and completion of a written test • Successful demonstration of procedural skills on airway simulators or mannequins • Successful demonstration of procedural skills on patients		

NM	Areas Reviewed (continued)	Findings	Recommendations
X	Reassessments for continued EAM competency were completed at the time of renewal of privileges or scope of practice and included: • Review of clinician-specific EAM data • Subject matter content elements and completion of a written test • Successful demonstration of procedural skills on airway simulators or mannequins • At least one occurrence of successful airway management and intubation in the preceding 2 years, written certification of competency by the supervisor, or successful demonstration of skills to the subject matter expert • A statement related to EAM if the clinician was not a licensed independent practitioner	• None of the 12 applicable clinicians had reassessments for continued EAM competency completed at the time of renewal of privileges or scope of practice.	**15.** We recommended that the facility ensure clinician reassessment for continued emergency airway management competency is completed at the time of renewal of privileges or scope of practice and that facility managers monitor compliance.
X	The facility had a clinician with EAM privileges or scope of practice available during all hours the facility provided patient care.	• None of the 30 sampled days had EAM coverage during all hours the facility provided patient care.	**16.** We recommended that the facility ensure a clinician with emergency airway management privileges or scope of practice is available during all hours the facility provides patient care and that facility managers monitor compliance.
	Video equipment to confirm proper placement of breathing tubes was available for immediate clinician use.		
	The facility complied with any additional elements required by VHA or local policy.		

MH RRTP

The purpose of this review was to determine whether the facility's MH RRTP and Psychosocial RRTP complied with selected EOC requirements.[h]

We reviewed relevant documents, inspected units 19-3 and 25-1B, and conversed with key employees. The table below shows the areas reviewed for this topic. Any items that did not apply to this facility are marked NA. The facility generally met requirements. We made no recommendations.

NM	Areas Reviewed	Findings	Recommendations
	The residential environment was clean and in good repair.		
NA	Appropriate fire extinguishers were available near grease producing cooking devices.		
	There were policies/procedures that addressed safe medication management and contraband detection.		
	MH RRTP employees conducted and documented monthly MH RRTP self-inspections that included all required elements, submitted work orders for items needing repair, and ensured correction of any identified deficiencies.		
	MH RRTP employees conducted and documented contraband inspections, rounds of all public spaces, daily bed checks, and resident room inspections for unsecured medications.		
	The MH RRTP had written agreements in place acknowledging resident responsibility for medication security.		
	MH RRTP main point(s) of entry had keyless entry and closed circuit television monitoring, and all other doors were locked to the outside and alarmed.		

NM	Areas Reviewed (continued)	Findings	Recommendations
	The MH RRTP had closed circuit television monitors with recording capability in public areas but not in treatment areas or private spaces and signage alerting veterans and visitors of recording.		
	There was a process for responding to behavioral health and medical emergencies, and MH RRTP employees could articulate the process.		
	In mixed gender MH RRTP units, women veterans' rooms had keyless entry or door locks, and bathrooms had door locks.		
	Residents secured medications in their rooms.		
	The facility complied with any additional elements required by VHA or local policy.		

Review Activities with Previous CAP Recommendations

Follow-Up on QM Issue

As a follow-up to a recommendation from our prior CAP review, we reassessed facility compliance with integrated ethics.

Integrated Ethics Improvement Cycles. VHA requires preventive ethics teams at each facility to perform a minimum of two improvement cycles each FY.[i] For the previous CAP review, the facility had completed only one improvement cycle during FY 2011. In response to the recommendation from that review, the facility reviewed the process for completing issue cycles and began monthly reporting of progress to the Integrated Ethics Committee. However, the facility completed only one improvement cycle during FY 2014.

Recommendation

17. We recommended that the facility complete at least two preventive ethics improvement cycles each fiscal year.

Follow-Up on COC Issue

As a follow-up to a recommendation from our prior CAP review, we reassessed facility compliance with follow-up appointments.

Follow-Up Appointments. VHA requires that discharge instructions include recommendations regarding the initial follow-up appointment.[j] For the previous CAP review, of the 16 patients whose providers requested specific follow-up timeframes, three appointments were not scheduled as requested. In response to the recommendation from that review, a facility workgroup monitored timeframes for follow-up appointments and provided feedback to appropriate service chiefs to improve scheduling practices. However, the facility reported monthly compliance for July, August, and September 2014 at only 58, 74, and 80 percent, respectively.

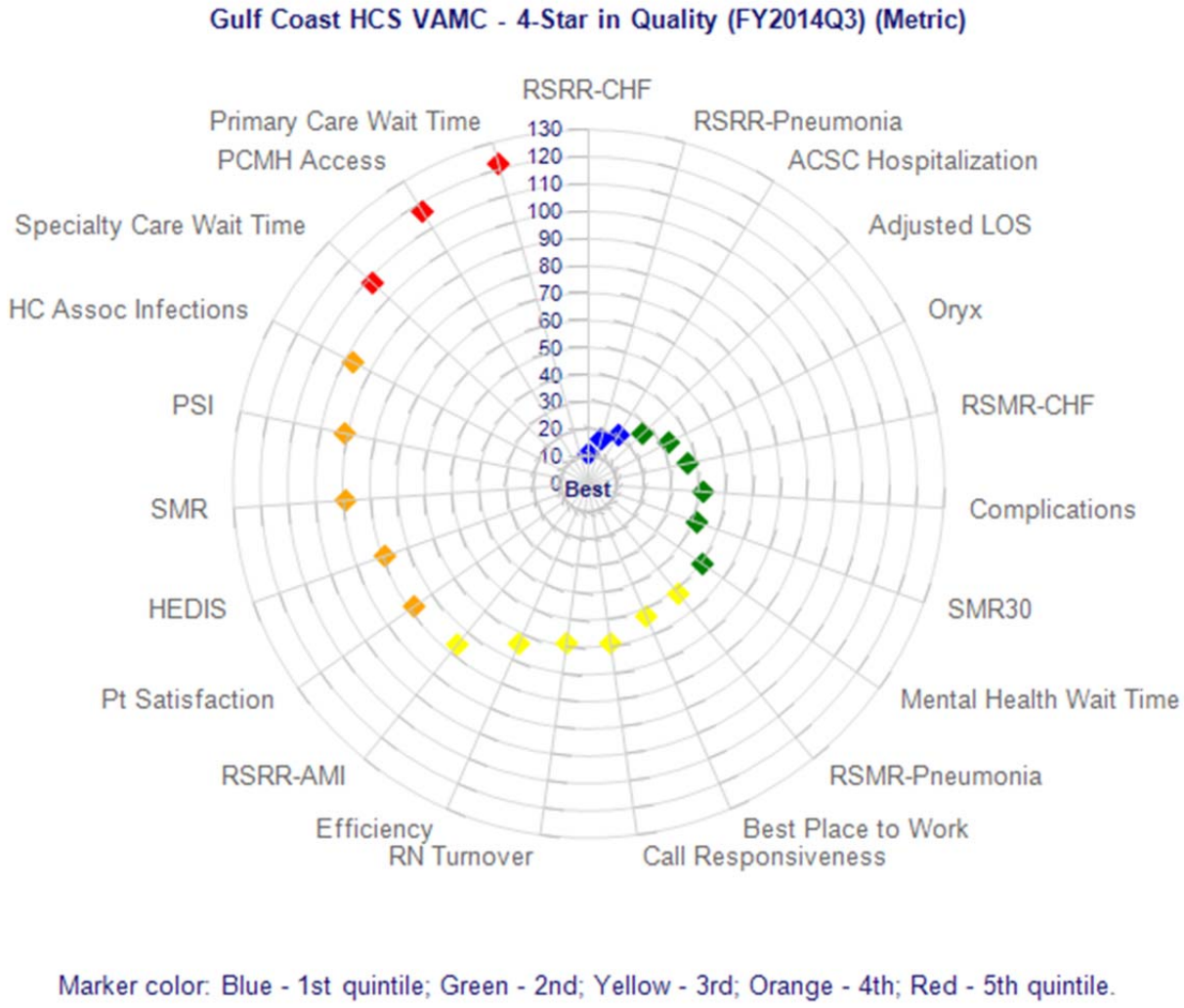
Recommendation

18. We recommended that the facility consistently schedule follow-up appointments within the timeframes requested by providers.

Facility Profile (Biloxi/520) FY 2014[1]	
Type of Organization	Tertiary
Complexity Level	1c-High complexity
Affiliated/Non-Affiliated	Affiliated
Total Medical Care Budget in Millions	$378.1
Number of:	
• **Unique Patients**	65,153
• **Outpatient Visits**	653,709
• **Unique Employees**[2]	1,836
Type and Number of Operating Beds (as of August):	
• **Hospital**	83
• **CLC**	101
• **MH**	72
Average Daily Census (as of August):	
• **Hospital**	64
• **CLC**	80
• **MH**	65
Number of Community Based Outpatient Clinics	4
Location(s)/Station Number(s)	Joint Ambulatory Care Center/520BZ Mobile/520GA Panama City/520GB Eglin/520GC
VISN Number	16

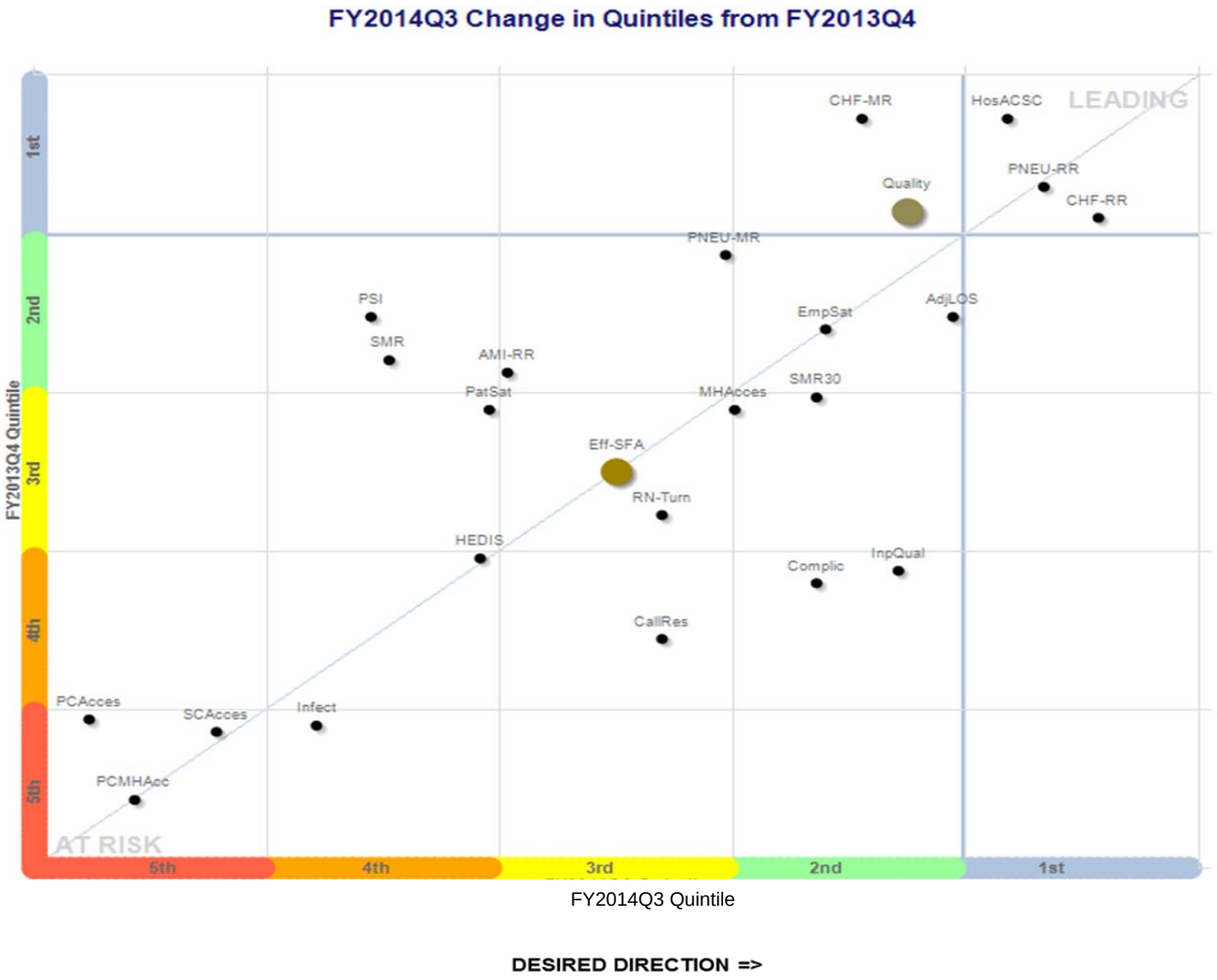
[1] All data is for the entire FY except where noted.
[2] Unique employees involved in direct medical care (cost center 8200) from most recent pay period.

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

Interim VISN Director Comments

Department of Veterans Affairs

Memorandum

Date: December 10, 2014

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

Subject: **CAP Review of the Gulf Coast Veterans Health Care System, Biloxi, MS**

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 (VISN 16) has reviewed and concur with the findings and recommendations included in the draft report submitted by the Gulf Coast Veterans Health Care System, Biloxi, MS.

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

Susan Easter

Susan Easter, MS, BSN, ANE-BC, NE-BC, CPHQ, VHA-CM
for and in the absence of
Gregg Parker, M.D., MHA
Interim Network Director
South Central VA Health Care Network (10N16)

Acting Facility Director Comments

Department of Veterans Affairs

Memorandum

Date: December 9, 2014

From: Acting Director, Gulf Coast Veterans Health Care System (520/00)

Subject: **CAP Review of the Gulf Coast Veterans Health Care System, Biloxi, MS**

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

1. Thank you for the opportunity to review this report. The professionalism of the OIG staff is worth noting as this contributed greatly to a thorough and beneficial assessment of health care system operations.

2. I concur with the recommendations outlined in the attached report. All findings have been reviewed and facility level action plans initiated as required.

3. If you have any questions, please feel free to contact Kelly D. Woods, PhD, Chief, Quality and Performance Management at (228) 523-4206.

Sincerely,

Bryan C. Matthews, MBA
Acting Medical Center Director

Comments to OIG's Report

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

OIG Recommendations

Recommendation 1. We recommended that facility managers review privilege forms annually and document the review.

Concur

Target date for completion: January 31, 2015

Facility response: A process has been put in place whereby, with the start of each new fiscal year, the Professional Credentials Committee will review privilege forms and submit the result of this review to the Executive Committee of the Medical staff. The annual review of privilege forms for Fiscal Year 2015 has been initiated through the Professional Credentials Committee. On November 17, 2014, Clinical Services (e.g., Medicine, Surgery, Behavioral Health, and Physical Rehabilitation & Medicine) were asked to review privilege forms utilized for their respective providers. By December 31, 2014, Services will report the results of their review to the Professional Credentials Committee (e.g., modify forms or maintain current forms). The Professional Credentials Committee will in turn provide a summary report to the Executive Committee of the Medical Staff. Completed actions will be reported to the Quality, Safety and Value Committee for tracking purposes.

Recommendation 2. We recommended that facility managers ensure employees receive training on chemical labeling/safety data sheets.

Concur

Target date for completion: January 31, 2015

Facility response: Staff requiring training on chemical labeling/safety data sheets have been identified and training has been initiated. To ensure that staff remain current with training requirements, random audits will be initiated by the Safety Office to determine compliance with required training on chemical labeling and safety data sheets. A minimum of 30 audits will be conducted per month. A compliance benchmark of 90% or greater is expected for three consecutive months. Findings will be reported to the Environment of Care Committee and the Quality, Safety and Value Committee for tracking purposes.

Recommendation 3. We recommended that facility managers ensure floors in patient care areas are clean and monitor compliance.

Concur

Target date for completion: February 28, 2015

Facility response: As part of Environment of Care Rounds, patient care areas are visited and inspected for cleanliness. An environmental checklist will be developed by Environmental Management Service whereby supervisors will document that their assigned patient care areas were inspected and meet standards and expectations of cleanliness. The Chief of Environmental Management Service will report the results of the checklists to the Environment of Care Committee.

Recommendation 4. We recommended that facility managers consult with the manufacturer regarding the issue of dirty-appearing sinks and take any recommended actions.

Concur

Target date for completion: Completed on November 5, 2014

Facility response: The sink manufacturer was contacted on November 5, 2014, and informed of the sink staining. Cleaning procedures and products were discussed and Environmental Management Service (EMS) has followed available guidance in cleaning the items. At this time, EMS will continue with the daily cleaning of the sinks and a once a week chemical cleaning to decrease the staining. In addition, Engineering Service has begun talks with the manufacturer concerning the product and possible replacement of the stained sinks.

Recommendation 5. We recommended that facility managers ensure all designated employees receive annual bloodborne pathogens training and monitor compliance.

Concur

Target date for completion: January 31, 2015

Facility response: Staff requiring training on Blood Borne Pathogens has been identified and training has been initiated. To ensure that staff remain current with training requirements, random audits of employee training records will be initiated by Infection Control staff on various employees throughout the health care system to determine compliance with required training within the last 12 months. A minimum of 30 records will be audited will be conducted per month. A compliance benchmark of 90% or greater is expected for three consecutive months. Findings will be submitted to the Infection Control Committee and the Quality, Safety and Value Committee for tracking purposes.

Recommendation 6. We recommended that the facility revise the policy for safe use of automated dispensing machines to include employee training and minimum competency requirements for users and that facility managers monitor compliance.

Concur

Target date for completion: January 31, 2015

Facility response: The facility's Automated Medication Dispensing System Station Memorandum (119-02) will be revised to include language that speaks to employee training and minimum requirements for users. Completed action will be reported to the Pharmacy & Therapeutics Committee and the Quality, Safety and Value Committee for tracking purposes.

Recommendation 7. We recommended that facility managers ensure designated employees receive automated dispensing machine training and competency assessment and monitor compliance.

Concur

Target date for completion: April 30, 2015

Facility response: Staff requiring training on automated dispensing machines has been identified and training initiated. To ensure that staff receive training and competency validation, random audits of employee training records will be initiated by assigned staff to determine compliance with required training and competency assessment for use of automated dispensing machines in accordance with station policy. A minimum of 30 records will be audited per month. A compliance benchmark of 90% or greater is expected for three consecutive months. Findings will be submitted to the Quality, Safety and Value Committee for tracking purposes.

Recommendation 8. We recommended that requestors consistently include "inpatient" in the consult title and that facility managers monitor compliance.

Concur

Target date for completion: February 28, 2015

Facility response: A review of consult titles has been completed to ensure proper titles, "inpatient," are available for provider usage. Random audits of inpatient electronic health records will be initiated by Utilization Management to ensure appropriate titles are being used for services that are requested during an inpatient admission. A minimum of 30 patient records will be conducted per month. A compliance benchmark of 90% or greater is expected for three consecutive months. Findings will be submitted to the Consult Oversight Committee and the Quality, Safety and Value Committee for tracking purposes.

Recommendation 9. We recommended that the facility develop and implement an acute ischemic stroke policy that addresses all required items.

Concur

Target date for completion: Completed on October 23, 2014

Facility response: The facility's acute ischemic stroke policy was published on October 23, 2014, after consultation with the OIG Team during the site visit. The policy meets all required elements.

Recommendation 10. We recommended that clinicians complete and document National Institutes of Health stroke scales for each stroke patient and that facility managers monitor compliance.

Concur

Target date for completion: February 28, 2015

Facility response: The newly-developed, comprehensive policy concerning acute ischemic stroke provides guidance to clinical staff on the completion and documentation of the National Institute of Health stroke scale. To ensure staff are compliant with completing and documenting the National Institute of Health stroke scale in accordance with the station policy, an audit of the electronic health record for each stroke patient identified at the facility will be completed by assigned staff. The audit will review the completion and documentation of a stroke scale for each identified patient. The number of patients who present with such a condition varies, so a 100% review of cases will be conducted each month up to 30 cases per month. A compliance benchmark of 90% or greater is expected for three consecutive months. Findings will be submitted to the Critical Care Committee and the Quality, Safety and Value Committee for tracking purposes.

Recommendation 11. We recommended that clinicians screen patients for difficulty swallowing prior to oral intake and that facility managers monitor compliance.

Concur

Target date for completion: February 28, 2015

Facility response: The newly-developed, comprehensive policy concerning acute ischemic stroke provides guidance to clinical staff on the screening of patients for difficulty swallowing prior to oral intake. To ensure that staff are compliant with screening patients for difficulty prior to oral intake in accordance with the newly-developed station policy, an audit of the electronic health record for each stroke patient identified at the facility will be completed by assigned staff. The audit will review the completion of a screen for patients with difficulty swallowing prior to oral intake. The number of patients who present with such a condition varies, so a 100% review of cases will be conducted each month up to 30 cases per month. A compliance benchmark of

90% or greater is expected for three consecutive months. Findings will be submitted to the Critical Care Committee and the Quality, Safety and Value Committee for tracking purposes.

Recommendation 12. We recommended that clinicians provide printed stroke education to patients upon discharge and that facility managers monitor compliance.

Concur

Target date for completion: February 28, 2015

Facility response: The newly-developed, comprehensive policy concerning acute ischemic stroke provides guidance to clinical staff on providing printed stroke education to patients upon discharge. To ensure that staff are compliant with providing printed stoke education to patients in accordance with the newly-developed station policy, an audit of the electronic health record for each stroke patient identified at the facility will be completed by assigned staff. The audit will review the documentation of printed educational materials provided to stroke patients upon discharge. The number of patients who present with such a condition varies, so a 100% review of cases will be conducted each month not up to 30 cases per month. A compliance benchmark of 90% or greater is expected for three consecutive months. Findings will be submitted to the Critical Care Committee and the Quality, Safety and Value Committee for tracking purposes.

Recommendation 13. We recommended that the facility collect and report to the Veterans Health Administration 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: February 28, 2015

Facility response: The newly-developed, comprehensive policy concerning acute ischemic stroke provides facility level guidance on collecting and reporting patient care information to the Veterans Health Administration. To ensure that staff are compliant with collecting and reporting required stroke information to the Veterans Health Administration in accordance with the newly-developed station policy, an audit of the electronic health record for each stroke patient identified at the facility will be completed by assigned staff. The audit will review the three metrics for information collection and reporting listed in the recommendation. In addition, the audit will include a review of the reporting status for the three metrics in relation to the uploading of information into the identified VHA database (i.e., IPEC) as required. The number of patients who present with such a condition varies, so a 100% review of cases will be conducted each month up to 30 cases per month. A compliance benchmark of 90% or greater is expected for three consecutive months. Findings will be submitted to the Critical Care Committee and the Quality, Safety and Value Committee for tracking purposes.

Recommendation 14. We recommended that the facility revise the emergency airway management policy to include the availability of videolaryngoscopes for use by clinicians and a plan for managing a difficult airway.

Concur

Target date for completion: February 28, 2015

Facility response: An interdisciplinary workgroup comprised of Surgical, Respiratory Therapy, Nursing and Quality staff has been formed to complete a review and revision of the facility's Emergency Airway Management Out of Operating Room Station Memorandum (11-101).

Recommendation 15. We recommended that the facility ensure clinician reassessment for continued emergency airway management competency is completed at the time of renewal of privileges or scope of practice and that facility managers monitor compliance.

Concur

Target date for completion: March 31, 2015

Facility response: An interdisciplinary workgroup comprised of Surgical, Respiratory Therapy, Nursing and Quality staff has been formed to complete a review and revision of the facility's Emergency Airway Management Out of Operating Room Station Memorandum (11-101). The new station memorandum will outline the policy for tracking compliance of clinician reassessment for continued emergency airway management competency at the time of renewal of privileges or scope of practice. Once the policy has been approved, an audit of clinician competencies will be initiated for the newly defined process. A compliance benchmark of 90% or greater is expected for three consecutive months. Findings will be submitted to the Critical Care Committee and the Quality, Safety and Value Committee for tracking purposes.

Recommendation 16. We recommended that the facility ensure a clinician with emergency airway management privileges or scope of practice is available during all hours the facility provides patient care and that facility managers monitor compliance.

Concur

Target date for completion: January 31, 2015

Facility response: During the visit, a revised coverage schedule was reviewed with the OIG Team Members. The revised schedule reflected coverage by staff who had the required emergency airway management privileges or scopes of practice for all hours the facility provides patient care. A review of all posted schedules will be conducted for three consecutive months to ensure the coverage is maintained as required. A compliance benchmark of 100% is expected.

Recommendation 17. We recommended that the facility complete at least two preventive ethics improvement cycles each fiscal year.

Concur

Target date for completion: August 31, 2015

Facility response: One improvement cycle for Fiscal Year 2014 was completed as required. The second was hindered by unexpected challenges in the implementation of strategies and compliance monitoring for the planned initiative. For Fiscal Year 2015, two improvement cycles have been identified and the Preventive Ethics Team will complete them both as required. The Preventive Ethics Coordinator will provide a monthly progress report to the Integrated Ethics Council. Actions will be submitted to the Quality, Safety and Value Committee for tracking purposes.

Recommendation 18. We recommended that the facility consistently schedule follow-up appointments within the timeframes requested by providers.

Concur

Target date for completion: April 30, 2015

Facility response: An interdisciplinary workgroup (e.g., Medicine, Surgery, Medical Administration, Social Work, and Utilization Management) will be established to review the process of discharges, discharge instructions, and inpatient provider expectations in relation to follow-up care for recently discharge patients. The intent of the group is to improve post discharge scheduling in line with inpatient provider orders for follow-up care. Post discharge case reviews will be conducted by Utilization Management staff for patients discharged from acute care areas to determine compliance with the timeframes requested by the providers. A minimum of 30 reviews will be conducted per month. A compliance benchmark of 90% or greater is expected for three consecutive months. Findings will be shared with the workgroup and submitted to the Quality, Safety and Value Committee for tracking purposes.

Office of Inspector General
Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the OIG at (202) 461-4720.
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Endnotes

[a] References used for this topic included:
- VHA Directive 1026, *VHA Enterprise Framework for Quality, Safety, and Value*, August 2, 2013.
- VHA Handbook 1050.01, *VHA National Patient Safety Improvement Handbook*, March 4, 2011.
- VHA Directive 2010-025, *Peer Review for Quality Management*, June 3, 2010.
- VHA Directive 2010-032, *Safe Patient Handling Program and Facility Design*, June 28, 2010.
- VHA Directive 1036, *Standards for Observation in VA Medical Facilities*, February 6, 2014.
- VHA Handbook 1100.19, *Credentialing and Privileging*, October 15, 2012.
- VHA Handbook 1102.01, *National Surgery Office*, January 30, 2013.
- 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*, July 22, 2014.

[b] References used for this topic included:
- VHA Directive 2010-052, *Management of Wandering and Missing Patients*, December 3, 2010.
- VHA Directive 2011-007, *Required Hand Hygiene Practices*, February 16, 2011.
- Under Secretary for Health, "Non- Research Animals in Health Care Facilities," Information Letter 10-2009-007, June 11, 2009.
- Various requirements of The Joint Commission, the Occupational Safety and Health Administration, 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 Directive 2008-027, *The Availability of Potassium Chloride for Injection Concentrate USP*, May 13, 2008.
- VHA Directive 2010-020, *Anticoagulation Therapy Management*, May 14, 2010.
- VHA Handbook 1108.01, *Controlled Substances (Pharmacy Stock)*, November 16, 2010.
- VHA Handbook 1108.05, *Outpatient Pharmacy Services*, May 30, 2006.
- VHA Handbook 1108.06, *Inpatient Pharmacy Services*, June 27, 2006.
- VHA Handbook 1108.07, *Pharmacy General Requirements*, April 17, 2008.
- Various requirements of The Joint Commission.

[d] The reference used for this topic was:
- Under Secretary for Health, "Consult Business Rule Implementation," memorandum, May 23, 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 Directive 2009-001, *Restructuring of VHA Clinical Programs*, January 5, 2009.
- VHA Directive 2010-018, *Facility Infrastructure Requirements to Perform Standard, Intermediate, or Complex Surgical Procedures*, May 6, 2010.

[g] References used for this topic included:
- VHA Directive 2012-032, *Out of Operating Room Airway Management*, October 26, 2012.
- VHA Handbook 1101.04, *Medical Officer of the Day*, August 30, 2010.

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

[i] The reference used for this topic was:
- VHA Handbook 1004.06, *Integrated Ethics*®, August 29, 2013.

[j] The reference used for this topic was:
- VHA Handbook 1907.01, *Health Information Management and Health Records*, July 22, 2014.