Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 14-04221-91

Combined Assessment Program Review of the Memphis VA Medical Center Memphis, Tennessee

January 27, 2015

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
EAM	emergency airway management
ED	Emergency Department
EHR	electronic health record
EOC	environment of care
facility	Memphis VA Medical Center
FY	fiscal year
MH	mental health
MRI	magnetic resonance imaging
NA	not applicable
NM	not met
OIG	Office of Inspector General
QM	quality management
VHA	Veterans Health Administration

Table of Contents

Executive Summary

Review Purpose: The purpose of the review was to evaluate selected health care facility operations, focusing on patient care quality and the environment of care, and to provide crime awareness briefings. We conducted the review the week of November 3, 2014.

Review Results: The review covered eight activities. The facility's reported accomplishments were opening the first equipment processing center in the Veterans Health Administration for reprocessing non-critical reusable medical equipment and helping to develop the first advanced environmental control units for veterans with severe disabilities.

Recommendations: We made recommendations in all eight of the following activities:

Quality Management: Consistently complete final peer reviews within required timeframes, and obtain written requests for extensions approved by the Facility Director. Ensure the Cardiopulmonary Resuscitation Committee fully reviews each code episode. Require the Surgical Work Group to meet monthly, include the Chief of Staff as a member, and review all surgical deaths with identified problems or opportunities for improvement. Include all required elements in the quality control policy for scanning.

Environment of Care: Require that Environment of Care-Safety Committee meeting minutes reflect sufficient discussion of deficiencies, corrective actions taken, and tracking of actions to closure. Ensure Infection Control Committee meeting minutes reflect implementation of actions to address high-risk areas and provide sufficient follow-up actions to address identified problems. Require that all designated critical care nurses receive hazardous material training. Ensure all isolation room negative pressure control systems are functional.

Medication Management: Ensure that all crash cart medications are current and that daily crash cart inspections are consistently documented and include all required elements. Complete monthly medication storage area inspections. Require that all designated employees receive annual automated dispensing machine training and competency assessment. Ensure that oral syringes are available for liquid medications in the Emergency Department and that they are stored separately from parenteral syringes.

Coordination of Care: Ensure requestors consistently select the proper consult title.

Magnetic Resonance Imaging Safety: Conduct initial patient safety screenings. Ensure all designated Level 1 ancillary staff receive annual level-specific magnetic resonance imaging safety training.

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. Post stroke guidelines in all areas where patients may present with stroke symptoms. Screen patients for difficulty swallowing prior to oral intake. Collect and report all required data elements to the Veterans Health Administration.

Surgical Complexity: Ensure nursing staff who perform 12-lead electrocardiograms have a current competency assessment and validation included in their competency checklists and have competency assessment and validation documentation completed. Require that post-anesthesia care competency assessment and validation is included in competency checklists for employees on the post-anesthesia care unit.

Emergency Airway Management: Revise the emergency airway management policy to include all Veterans Health Administration required elements. Ensure clinician reassessment for continued emergency airway management competency includes all required subject matter content elements, a written exam, and evidence of successful demonstration of all required procedural skills on airway simulators or mannequins. Require that video laryngoscopes are available in all designated locations.

Comments

The Veterans Integrated Service Network and Facility Directors agreed with the Combined Assessment Program review findings and recommendations and provided acceptable improvement plans. (See Appendixes C and D, pages 27–38, for the full text of the Directors' comments.) We consider recommendations 3, 5, 9, 12, 22, and 23 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
- MRI Safety
- Acute Ischemic Stroke Care
- Surgical Complexity
- EAM

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 2014 and FY 2015 through November 3, 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 Memphis VA Medical Center, Memphis, Tennessee,* Report No. 11-03654-66, January 19, 2012).

During this review, we presented crime awareness briefings for 149 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 408 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

Equipment Processing Center

Cleaning and decontaminating reusable medical equipment that does not require high-level disinfection or sterilization (such as hospital beds, equipment poles, and stretchers) can be difficult due to the sheer volume and mobility of the equipment. The facility was the first within VHA to staff and implement a service solely for this purpose and opened the VaproQuip™ Decontamination Room on September 30, 2013. Multiple pieces of equipment are placed in the decontamination room and decontaminated at the same time when a sterilant vapor is dispersed throughout the room. Employees refer to the room as the "Raypod" after the employee who was instrumental in implementing the service.

Advanced Environmental Controls Project

The facility's biomedical engineering team helped develop advanced environmental control units. The units allow veterans with severe disabilities to have control over their environment through voice activation, sip n' puff controls, touchscreen, and head/eye pupil movement. The facility was the first to install the units, and they are now being installed in the other 23 spinal cord injury units in VHA.

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 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
	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.		
X	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.	For the 12-month period May 1, 2013, through April 30, 2014: • For several deaths, clinicians did not consistently complete final peer reviews within 120 days, and there were no written requests for extensions approved by the Facility Director.	**1.** We recommended that clinicians consistently complete final peer reviews within required timeframes and obtain written requests for extensions approved by the Facility Director and that facility managers monitor compliance.

NM	Areas Reviewed (continued)	Findings	Recommendations
	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.		
	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.		
X	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.	Twelve months of Cardiopulmonary Resuscitation Committee meeting minutes reviewed: • The committee did not fully review each episode.	**2.** We recommended that the Cardiopulmonary Resuscitation Committee fully review each code episode.

NM	Areas Reviewed (continued)	Findings	Recommendations
X	The surgical review process met selected requirements: • An interdisciplinary committee with appropriate leadership and clinical membership met monthly to review surgical processes and outcomes. • The Surgical Work Group reviewed surgical deaths with identified problems or opportunities for improvement. • The Surgical Work Group reviewed additional data elements.	• The Surgical Work Group only met four times over the past 12 months. Four months of Surgical Work Group meeting minutes reviewed: • The Chief of Staff was not a member. Several surgical deaths that occurred May 1, 2013–April 30, 2014, had identified problems or opportunities for improvement: • One death was not reviewed.	**3.** We recommended that the Surgical Work Group meet monthly and include the Chief of Staff as a member. **4.** We recommended that the Surgical Work Group review all surgical deaths with identified problems or opportunities for improvement.
	Clinicians appropriately reported critical incidents.		
	The safe patient handling program met selected requirements: • A committee provided program oversight. • The facility 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.		
X	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.	• The facility's current policy did not address the quality of scanned documents, a correction process, or review to ensure readability.	**5.** We recommended that the quality control policy for scanning include all required elements.

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.[b]

We inspected the medical intensive care unit, surgical intensive care unit, spinal cord injury units (west and east), medical/surgical unit (3F), locked inpatient MH units (1C and 1D), and dialysis units. We also inspected the ED and the chemotherapy clinic and performed a perimeter inspection of the operating room construction site. Additionally, we reviewed relevant documents, including inspection documentation for 10 alarm-equipped medical devices in critical care, and 20 employee training records (16 critical care nurse and 4 housekeeper) 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
X	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.	Six months of EOC-Safety Committee meeting minutes reviewed: • Minutes did not reflect sufficient discussion of deficiencies, corrective actions taken, and tracking of actions to closure.	**6.** We recommended that Environment of Care-Safety Committee meeting minutes reflect sufficient discussion of deficiencies, corrective actions taken, and tracking of actions to closure.
X	The facility conducted an infection prevention risk assessment and implemented actions to address high-risk areas.	Infection prevention risk assessment and 8 months of Infection Control Committee meeting minutes reviewed: • Minutes did not reflect implementation of actions to address the high-risk areas of hand hygiene, construction projects, and Legionella and dialysis water testing results.	See recommendation 7.
X	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.	Eight months of Infection Control Committee meeting minutes reviewed: • Minutes did not reflect sufficient discussion of follow-up on actions implemented to address identified problems.	**7.** We recommended that Infection Control Committee meeting minutes reflect implementation of actions to address high-risk areas and provide sufficient follow-up actions to address identified problems.

NM	Areas Reviewed for General EOC (continued)	Findings	Recommendations
	The facility had established a process for cleaning equipment.		
X	Selected employees received training on updated requirements regarding chemical labeling and safety data sheets.	• Fifteen of the 16 critical care nurses' training records did not contain evidence of completion of hazardous material training.	**8.** We recommended that facility managers ensure all designated critical care nurses receive hazardous material training and monitor compliance.
	The facility met fire safety requirements.		
	The facility met environmental safety requirements.		
	The facility met infection prevention requirements.		
	The facility met medication safety and security requirements.		
	The facility met auditory privacy requirements.		
X	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.	Local policy requires negative pressure control systems to be functional. The Centers for Disease Control and Prevention requires that facilities maintain a continuous negative air pressure system in rooms designated for airborne isolation. • Neither of the two negative pressure control systems in the ED isolation rooms was functional.	**9.** We recommended that facility managers ensure all negative pressure control systems in isolation rooms are functional and monitor compliance.
	Areas Reviewed for Critical Care		
	Designated critical care employees received blood borne pathogens training during the past 12 months.		

NM	Areas Reviewed for Critical Care (continued)	Findings	Recommendations
	Alarm-equipped medical devices used in critical care were inspected 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.		
	The facility met medical equipment requirements in critical care.		
	The facility met patient privacy requirements in critical care.		
X	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.	Local policy and Centers for Disease Control and Prevention requirements reviewed: • The negative pressure control system was not functional in one of the two surgical intensive care unit isolation rooms.	See recommendation 9.
	Areas Reviewed for CLC		
NA	Designated CLC employees received blood borne pathogens training during the past 12 months.		
NA	For CLCs with resident animal programs, the facility conducted infection prevention risk assessments and had policies addressing selected requirements.		

NM	Areas Reviewed for CLC (continued)	Findings	Recommendations
NA	For CLCs with elopement prevention systems, the facility documented functionality checks at least every 24 hours and documented complete system checks annually.		
NA	The facility met environmental safety requirements in the CLC.		
NA	The facility met infection prevention requirements in the CLC.		
NA	The facility met medication safety and security requirements in the CLC.		
NA	The facility met medical equipment requirements in the CLC.		
NA	The facility met privacy requirements in the CLC.		
NA	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.		
	Areas Reviewed for Construction Safety		
	The facility met selected dust control, temporary barrier, storage, and security requirements for the construction site perimeter.		
	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 19 nursing employees, and pharmacy monthly medication storage area inspection documentation for the past 6 months. Additionally, we inspected a medical/surgical unit (2 South), the ED, the medical intensive care unit, and the post-anesthesia care unit 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 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
	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.		
X	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.	• Five crash carts had expired medications. Additionally, from August to the first week of November 2014, there was no documentation of some daily inspections, and some documented inspections were missing dates and signatures.	**10.** We recommended that facility managers ensure all crash cart medications are current and daily crash cart inspections are consistently documented and include all required elements and that facility managers monitor compliance.
	The facility prohibited storage of potassium chloride vials 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 and 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.		
X	The facility conducted and documented inspections of all medication storage areas at least every 30 days, fully implemented corrective actions, and monitored the changes.	• The medical intensive care unit, the post-anesthesia care unit, and a medical/surgical unit (5 East) had one or more missed monthly medication storage area inspections.	**11.** We recommended that facility managers ensure monthly medication storage area inspections are completed and monitor compliance.
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.	• Five nursing staff training records did not contain evidence of annual training or competency assessments for the automated dispensing machines.	**12.** We recommended that facility managers ensure designated employees receive annual automated dispensing machine training and competency assessment and monitor compliance.
X	The facility employed practices to prevent wrong-route drug errors.	• In the ED, oral syringes were not available for staff to administer liquid medications when dose amounts differed from the unit dose packages supplied, and staff reported they were using parenteral syringes instead.	**13.** We recommended that facility managers ensure that oral syringes are available for liquid medications in the Emergency Department and that they are stored separately from parenteral syringes to minimize the risk of wrong-route medication errors.

NM	Areas Reviewed (continued)	Findings	Recommendations
	Medications prepared but not immediately administered contained labels with all required elements.		
	The facility removed medications awaiting destruction or stored them separately from medications available for administration.		
	The facility met multi-dose insulin pen requirements.		
	The facility complied with any additional elements required by VHA or local policy.		

Coordination of Care

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 46 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.	• Nineteen consult requests (41 percent) did not include "inpatient" in the title.	**14.** We recommended that requestors consistently select the proper consult title and that facility managers monitor compliance.
	The facility met any additional elements required by VHA or local policy.		

MRI Safety

The purpose of this review was to determine whether the facility ensured safety in MRI in accordance with VHA policy requirements related to: (1) staff safety training, (2) patient screening, and (3) risk assessment of the MRI environment.[e]

We reviewed relevant documents and the training records of 38 employees (30 randomly selected Level 1 ancillary staff and 8 designated Level 2 MRI personnel), and we conversed with key managers and employees. We also reviewed the EHRs of 35 randomly selected patients who had an MRI January 1–December 31, 2013. Additionally, we conducted physical inspections of two MRI areas. The table below shows the areas reviewed for this topic. The areas marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

NM	Areas Reviewed	Findings	Recommendations
	The facility completed an MRI risk assessment, had documented procedures for handling emergencies in MRI, and conducted emergency drills in the MRI area.		
X	Patients had two safety screenings conducted prior to MRI; the patient, family member, or caregiver signed the secondary patient safety screening form; and a Level 2 MRI personnel reviewed and signed the secondary patient safety screening form.	• Four EHRs (11 percent) did not contain initial patient safety screenings.	**15.** We recommended that the facility conduct initial patient safety screenings and that facility managers monitor compliance.
	Secondary patient safety screening forms contained notations of any MRI contraindications, and a Level 2 MRI personnel and/or radiologist addressed the contraindications and documented resolution prior to MRI.		
X	The facility designated Level 1 ancillary staff and Level 2 MRI personnel and ensured they received level-specific annual MRI safety training.	• Five Level 1 ancillary staff (17 percent) did not receive level-specific annual MRI safety training.	**16.** We recommended that the facility ensure all designated Level 1 ancillary staff receive annual level-specific magnetic resonance imaging safety training and that facility managers monitor compliance.

NM	Areas Reviewed (continued)	Findings	Recommendations
	The facility had signage and barriers 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 facility regularly tested the two-way communication device.		
	The facility provided patients with MRI-safe hearing protection for use during the scan.		
	The facility had only MRI-safe or compatible equipment in Zones III and IV or appropriately protected the equipment from the magnet.		
	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.[f]

We reviewed relevant documents, the EHRs of 41 randomly selected patients who experienced stroke symptoms, and 37 ED employee training records, and we conversed with key employees. We also conducted onsite inspections of the ED, two critical care units, 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.	**17.** 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 16 of the patients (39 percent), clinicians did not document evidence of completion of stroke scales.	**18.** 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.		
X	Facility managers posted stroke guidelines in all areas where patients may present with stroke symptoms.	• Facility managers had not posted stroke guidelines in the ED, on the two critical care units, or on the acute inpatient unit.	**19.** We recommended that facility managers post 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 seven of the patients (17 percent), clinicians did not document in the EHRs that they screened the patients for difficulty swallowing prior to oral intake.	**20.** We recommended that clinicians screen patients for difficulty swallowing prior to oral intake and that facility managers monitor compliance.
	Clinicians provided printed stroke education to patients upon discharge.		

NM	Areas Reviewed	Findings	Recommendations
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	**21.** 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.[g]

We reviewed relevant documents and the training records of 14 employees, and we conversed with key managers and employees. The table below shows the areas reviewed for this topic. The area marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

NM	Areas Reviewed	Findings	Recommendations
	Facility policy defined appropriate availability for all support services required by VHA for the facility's surgical designation.		
X	Employees providing selected tests and patient care after operational hours had appropriate competency assessments and validation.	• Neither of the two employees on 2 South had 12-lead electrocardiogram competency assessment and validation included in their competency checklists. • None of the three employees on 2F had 12-lead electrocardiogram competency assessment and validation documentation completed. • None of the four post-anesthesia unit employees had post-anesthesia care competency assessment and validation included in their competency checklists.	**22.** We recommended that facility managers ensure that nursing staff who perform 12-lead electrocardiograms have a current competency assessment and validation included in their competency checklists and have competency assessment and validation documentation completed. **23.** We recommended that facility managers ensure post-anesthesia care competency assessment and validation is included in competency checklists for employees on the post-anesthesia care unit.
	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 Veterans Integrated Service Network 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.[h]

We reviewed relevant documents, including competency assessment documentation of 16 clinicians applicable for the review period January 1 through June 30, 2014, 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 a specified plan for managing a difficult airway and did not require the use of video laryngoscopes. • Facility policy did not contain an alternative method for competency assessment of new employees, transfers in from other VA medical centers, consultants, or without compensation clinicians.	**24.** We recommended that the facility revise the emergency airway management policy to include all Veterans Health Administration required elements.

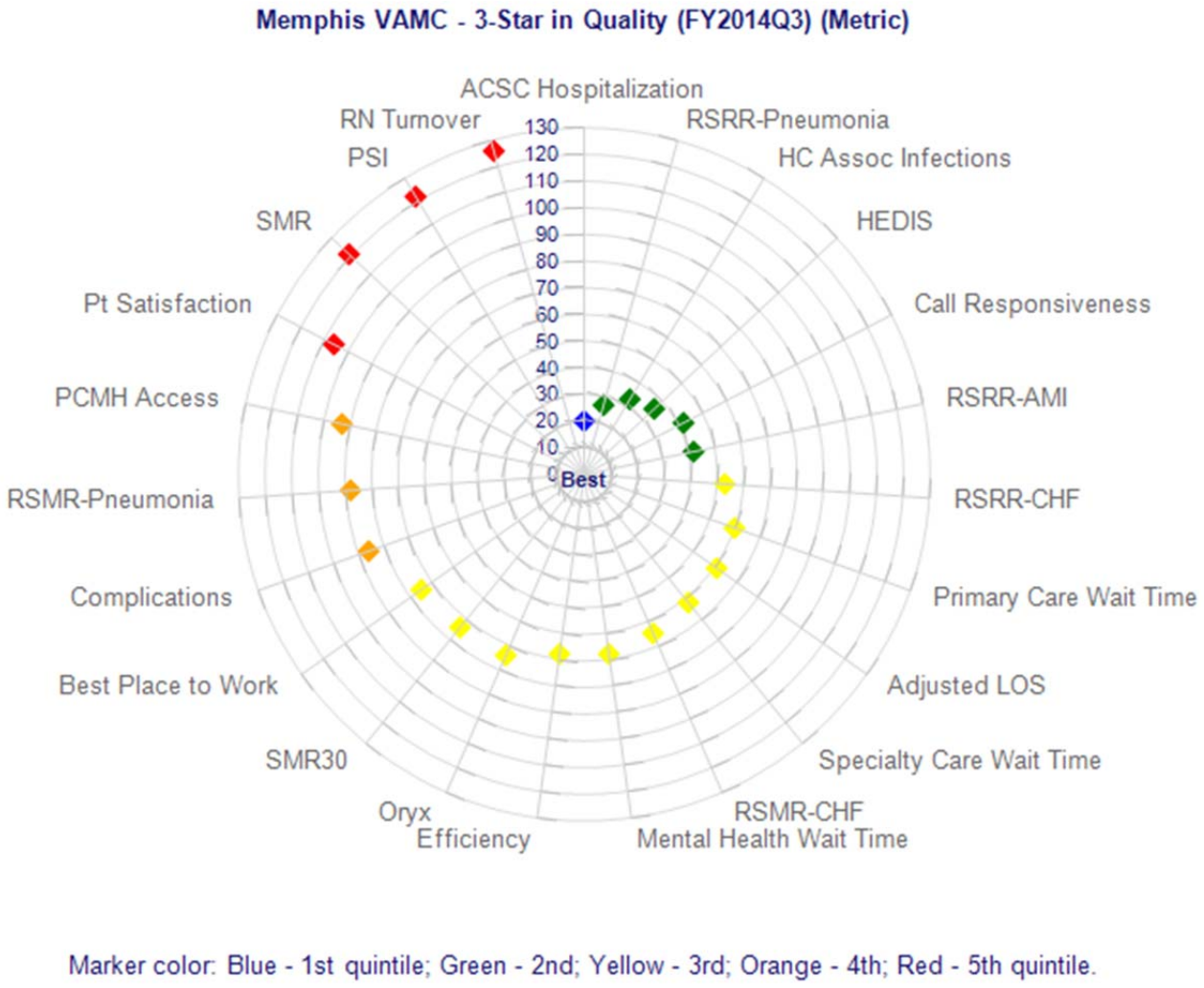
NM	Areas Reviewed (continued)	Findings	Recommendations
	Initial competency assessment for EAM included: • Subject matter content elements and completion of a written test • Successful demonstration of procedural skills on airway simulators or mannequins • Successful demonstration of procedural skills on patients.		
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.	• Three of the 16 clinicians did not have documentation of any of the required subject matter content elements or a completed written exam. • None of the16 clinicians had evidence of successful demonstration of all required procedural skills on airway simulators or mannequins.	**25.** We recommended that the facility ensure clinician reassessment for continued emergency airway management competency includes all required subject matter content elements and a written exam and that facility managers monitor compliance. **26.** We recommended that the facility ensure that clinician reassessment for continued emergency airway management competency includes evidence of successful demonstration of all required procedural skills on airway simulators or mannequins and that facility managers monitor compliance.
	The facility had a clinician with EAM privileges or scope of practice or an anesthesiology staff member available during all hours the facility provided patient care.		
X	Video equipment to confirm proper placement of breathing tubes was available for immediate clinician use.	• The facility did not have video laryngoscopes available for immediate clinician use in one of the two designated locations.	**27.** We recommended that facility managers ensure video laryngoscopes are available in all designated locations and monitor compliance.

NM	Areas Reviewed (continued)	Findings	Recommendations
NA	The facility complied with any additional elements required by VHA or local policy.		

Facility Profile (Memphis/614) FY 2015 through November 2014[1]	
Type of Organization	Tertiary
Complexity Level	1a-High complexity
Affiliated/Non-Affiliated	Affiliated
Total Medical Care Budget in Millions	$362.7
Number of:	
• **Unique Patients**	30,786
• **Outpatient Visits**	88,742
• **Unique Employees**[2]	1,903
Type and Number of Operating Beds (as of October):	
• **Hospital**	244
• **CLC**	NA
• **MH**	16
Average Daily Census (as of October):	
• **Hospital**	143
• **CLC**	NA
• **MH**	21
Number of Community Based Outpatient Clinics	9
Location(s)/Station Number(s)	Smithville/614GA Jonesboro/614GB Holly Springs/614GC Savannah/614GD Memphis/614GE Memphis/614GF Jackson/614GG Dyersburg/614GI Helena/614GN
Veterans Integrated Service Network Number	9

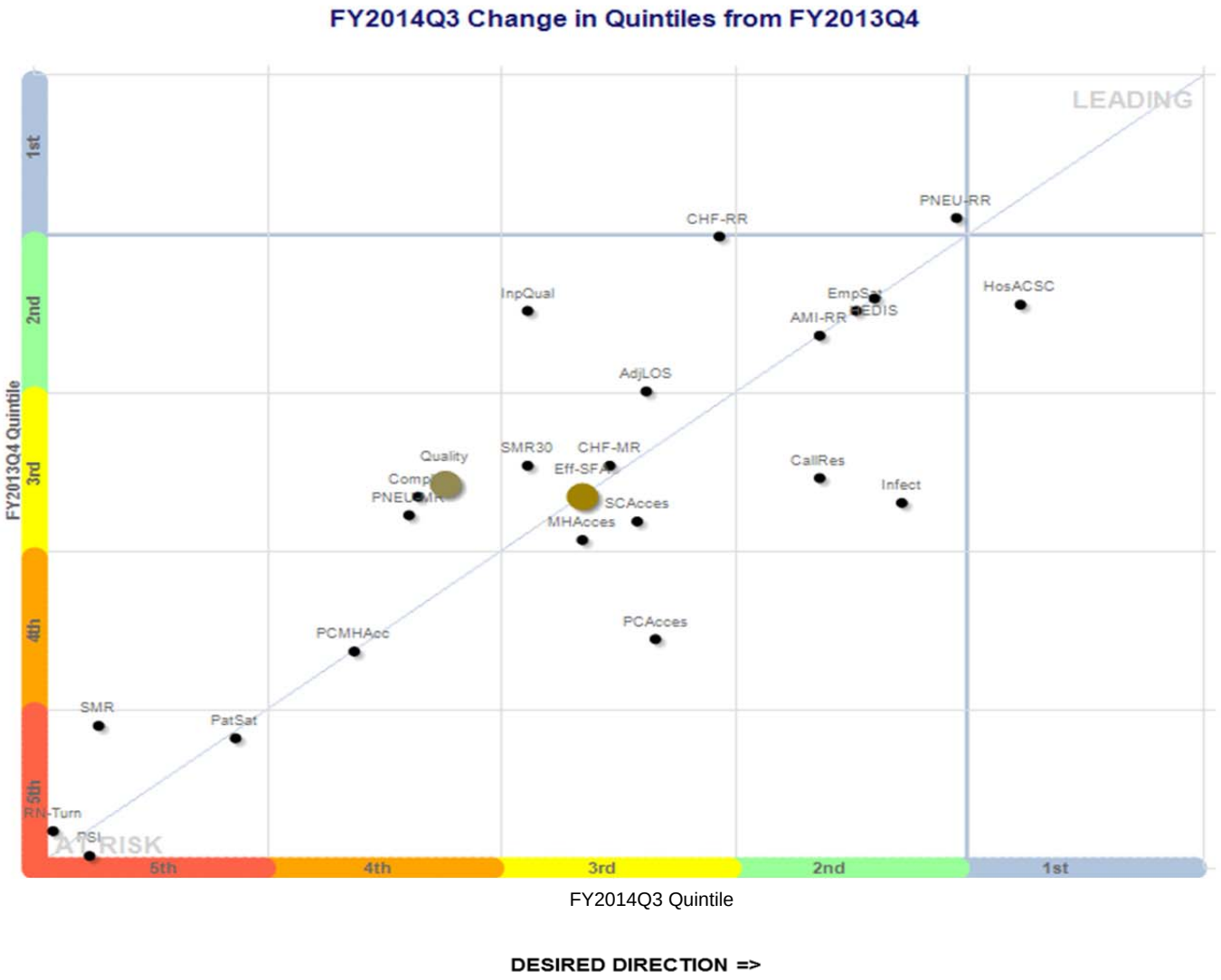
[1] All data is for FY 2015 through November 2014 except where noted.
[2] Unique employees involved in direct medical care (cost center 8200) from most recent pay period.

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



[3] Metric definitions follow the graphs.

Scatter Chart



DESIRED DIRECTION =>

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

Veterans Integrated Service Network Director Comments

Department of Veterans Affairs

Memorandum

Date: December 29, 2014

From: Director, VA Mid South Healthcare Network (10N9)

Subject: **CAP Review of the Memphis VA Medical Center, Memphis, TN**

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

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

1. I concur with the findings and recommendations of the Draft Report of the Office of Inspector General Combined Assessment Program (OIG CAP) Review conducted November 3–7, 2014, as well as the action plan developed by the facility.

2. If you have questions or need additional information from the Network, do not hesitate to contact Joe Schoeck, HSS/Staff Assistant to the Network Director.

Facility Director Comments

Department of Veterans Affairs

Memorandum

Date: December 19, 2014

From: Director, Memphis VA Medical Center (614/00)

Subject: **CAP Review of the Memphis VA Medical Center, Memphis, TN**

To: Director, VA Mid South Healthcare Network (10N9)

1. Attached please find the VA Medical Center at Memphis, Tennessee's response to the Draft Report of the Office of Inspector General Combined Assessment Program (OIG CAP) Review conducted November 3–7, 2014.

2. If you have any questions regarding the information provided, please contact Jan Slate, Accreditation Manager, Quality Management and Performance Improvement. Mrs. Slate can be reached at (901) 577-7379 menu choice #5.

C. DIANE KNIGHT, MD

Attachment

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 clinicians consistently complete final peer reviews within required timeframes and obtain written requests for extensions approved by the Facility Director and that facility managers monitor compliance.

Concur

Target date for completion: February 20, 2015

Facility response: During the OIG CAP site visit the facility produced written requests for extensions and noted receipt of verbal approval for the extension; however, could not provide written approval of the extension. This practice changed immediately. If an extension is needed, the Risk Manager will obtain the written approval from the Facility Director. This will be monitored monthly.

Recommendation 2. We recommended that the Cardiopulmonary Resuscitation Committee fully review each code episode.

Concur

Target date for completion: February 27, 2015

Facility response: Effective December 12, 2014, Nursing Service formalized the process of tracking the Blue Alert Forms daily to assure that the forms get to the CPR Committee. The ADPCS reviews blue alerts at Nursing Morning Report to assure that the forms are present from the previous administrative workday. If the report is missing, the Nurse Manager for the area will be contacted by the ADPCS, asked to find the blue alert form and turn it into the ADPCS office by Noon. It will be then reviewed by the ADPCS and given to the Nursing Service secretary to be date stamped and scanned before passing on to the Risk Manager who forwards the form to the CPR Committee. Monitoring will occur for two months to ensure the tracking process is in place.

Recommendation 3. We recommended that the Surgical Work Group meet monthly and include the Chief of Staff as a member.

Concur

Target date for completion: Completed

Facility response: Although Surgical Service has had monthly meetings of the Mortality & Morbidity Conference (M&M) and quarterly meetings of the Facility Surgical Work

Group and Surgical Quality Management Workgroup since October 2013, these meetings were not identified as the Facility Surgical Work Group. This has been corrected. As of November, the minutes are reflecting the monthly Facility Surgical Work Group.

In November 2014, the secretary for the Chief of Staff verified that the Facility Surgical Work Group (FSWG) meeting is a recurring appointment on the COS calendar. When the COS is unable to attend, a representative will be sent to attend in his/her place.

Recommendation 4. We recommended that the Surgical Work Group review all surgical deaths with identified problems or opportunities for improvement.

Concur

Target date for completion: Completed

Facility response: Surgical Service has had monthly meetings of the Mortality & Morbidity Conference (M&M) since October 2013. It was noted during the OIG CAP review that one death had not been reviewed during the facility M&M. This death occurred in September 2013 and was reviewed at the University of Tennessee M&M Conference (affiliate). As of November 2014, the Chief, Surgical Service is ensuring that all deaths are reviewed during the monthly FSWG.

Recommendation 5. We recommended that the quality control policy for scanning include all required elements.

Concur

Target date for completion: Completed

Facility response: Facility policy for Image and Document Import/Scanning was signed and published on December 12, 2014. The policy specifically addresses the requirements for processing documents that are determined to be of "poor quality" prior to scanning. The policy outlines the process that will be followed when an error is noted and when and who should be contacted for image correction/deletion. The policy outlines the quality controls that must be in place by all services/sections that are scanning/importing images. The steps for Quality Assurance Procedures are outlined in Attachment B of the facility policy (MCM 136-08) as well as all reporting requirements of Quality Assurance reviews.

The FY15 scanning QA reviews for HIMS/File Room staff have been completed according to the steps outlined in the policy. Results show an outstanding accuracy rate:

- October 2014
  - 3,447 entries
  - 22,815 pages
  - 95.62% accuracy

- November 2014
  - 4,099 entries
  - 18,244 pages
  - 99.51% accuracy

Chief, HIMS will complete 50 reviews each month for the HIMS/File Room staff that scans. Chief, HIMS is conducting training on the QA process, as outlined in the published policy, with supervisors of staff who do decentralized scanning within the facility.

Recommendation 6. We recommended that Environment of Care-Safety Committee meeting minutes reflect sufficient discussion of deficiencies, corrective actions taken, and tracking of actions to closure.

Concur

Target date for completion: March 31, 2015

Facility response: The Environment of Care Committee minutes will include detailed discussion of deficiencies noted in reports, measures and inspections that are presented for the reporting period, and corrective actions needed. The Committee has populated an "action tracker" with open tasks/responsible parties for issues the Committee continues to follow. In the January 2015 Committee meeting the "action tracker" will be used to update actions for open tasks. Monthly updates of items on the action tracker will occur until closure. Compliance will be monitored through review of minutes until at least 90 percent compliance is achieved for three months.

Recommendation 7. We recommended that Infection Control Committee meeting minutes reflect implementation of actions to address high-risk areas and provide sufficient follow-up actions to address identified problems.

Concur

Target date for completion: March 31, 2015

Facility response: Effective November 18, 2014, Infection Prevention Practitioners incorporated recommended changes to the committee minutes to include reporting, discussion, and follow-up actions on all high-risk areas being followed by Infection Prevention. A section for high-risk items was added as part of the standing agenda for the Infection Control meeting. Compliance will be monitored by the Quality, Safety and Values Board for three months with the expectation of 100 percent compliance.

Recommendation 8. We recommended that facility managers ensure all designated critical care nurses receive hazardous material training and monitor compliance.

Concur

Target date for completion: January 9, 2015

Facility response: Nursing Service has reviewed competencies and now all 36 (100%) MICU RN staffs have completed hazardous materials training. SICU RN staffs are 90% complete with the hazardous material training. Remaining staff training will be completed by January 9, 2015. The ADPCS/Nurse Executive will receive a report on January 7 to verify the status of training completion to ensure 100 percent training is completed by January 9.

Recommendation 9. We recommended that facility managers ensure all negative pressure control systems in isolation rooms are functional and monitor compliance.

Concur

Target date for completion: Completed

Facility response: By November 6, 2014, Engineering Service confirmed that the isolation rooms identified as deficient during the OIG CAP site visit were functional in negative pressure status. Specifically, the two rooms in the ED area are functioning correctly as negative pressure status. This has been confirmed multiple times with smoke tests.

During the OIG CAP site visit one room in SICU had a faulty monitor. This was corrected by November 6, 2014. A smoke test was completed on this room, and it was confirmed that the negative pressure was working. It should be noted that older monitoring equipment throughout the medical center are being replaced by a current construction contract; it is expected this will be completed within the next two months.

Anytime a patient is going to be put into isolation, the staff contacts Engineering Service. Engineering Service personnel perform a smoke test prior to the patient being placed in the room. Engineering also performs a daily test for the duration that the patient is in the room. The fans that serve the isolation rooms are monitored on the building management system. The fans have alarms so that if something were to occur, Engineering Service would be notified immediately if there was a malfunction and the room was to go positive. In addition, Engineering Service performs a monthly smoke test on all isolation rooms to ensure that the rooms are functional as a negative pressure room.

Recommendation 10. We recommended that facility managers ensure all crash cart medications are current and daily crash cart inspections are consistently documented and include all required elements and that facility managers monitor compliance.

Concur

Target date for completion: March 31, 2015

Facility response: Current Nursing Service policy requires daily checks of all crash carts. As a result of this recommendation, Nursing Service now requires each Nurse Manager to report weekly to his/her Chief Nurse on crash carts including: access to crash carts, security of crash carts, proper documentation on the crash cart, fill status of

oxygen tanks, and proper function of the defibrillator on the crash cart. This will be done for 3 months to assure improvement and full compliance is in place. In addition, the tracking Board for all crash carts with location and date each one expires was completed November 1, 2014. The tracking Board is maintained and reviewed by Chief, SPS.

Recommendation 11. We recommended that facility managers ensure monthly medication storage area inspections are completed and monitor compliance.

Concur

Target date for completion: March 31, 2015

Facility response: As a result of this recommendation, the Nurse Managers of all inpatient areas will now report on the medication storage areas weekly to the Chief Nurse rather than the previous monthly routine. They will report on expired medications, multi-dose vials for expiration date, and cleanliness of the medication room. The ADPCS has defined this as a performance measure for the Nurse Managers. This will be done for 3 months to assure improvement and full compliance is in place.

Recommendation 12. We recommended that facility managers ensure designated employees receive annual automated dispensing machine training and competency assessment and monitor compliance.

Concur

Target date for completion: Completed

Facility response: On December 8, 2014, the Nurse Managers were given a current competency on Med-Select, and all nurses were updated on their competency for the use of med-select, as per policy, on all inpatient units by December 18, 2014.

Recommendation 13. We recommended that facility managers ensure that oral syringes are available for liquid medications in the Emergency Department and that they are stored separately from parenteral syringes to minimize the risk of wrong-route medication errors.

Concur

Target date for completion: January 31, 2015

Facility response: Amber 10 ml oral syringes have been ordered by Logistics to use for oral medications by nursing staff rather than Luer lock. The different color and tip will make it easy to distinguish from the regular Luer lock, and the syringes will be stored in a separate bin from the Luer lock syringes. All nursing staff will be educated by January 9, 2015, on the new oral syringe and its intended use. Logistics Service states the new Amber oral syringes will be available by early January. In addition, Pharmacy

Service is working to develop a process that will have all oral liquid medications come pre-packaged to the inpatient units.

Recommendation 14. We recommended that requesters consistently select the proper consult title and that facility managers monitor compliance.

Concur

Target date for completion: March 31, 2015

Facility response: The facility CAC Supervisor has cleaned up all consult titles. Clinicians will order "outpatient" consults for care to be rendered as an outpatient and "inpatient" consults for care to be rendered as an inpatient. An action plan will be mandated for consults that are in the pending, active, scheduled or incomplete status for greater than the mandated time frames. Consult completion will be monitored by the Consult Committee. Samples of inpatient consults will be reviewed by the Committee to ensure they are for inpatient services, and outpatient consults will be similarly monitored. This monitor will be done for the next three months.

Recommendation 15. We recommended that the facility conduct initial patient safety screenings and that facility managers monitor compliance.

Concur

Target date for completion: March 31, 2015

Facility response: An MRI safety screening template used in the ordering process in CPRS has been in place and working within the facility. This template serves as the initial patient safety screen. The MRI Safety Committee will include reviews of compliance metrics for use of the template as the medical center strives for full compliance.

Recommendation 16. We recommended that the facility ensure all designated Level 1 ancillary staff receive annual level-specific magnetic resonance imaging safety training and that facility managers monitor compliance.

Concur

Target date for completion: February 27, 2015

Facility response: The facility has made substantial improvements to ensure MRI safety training is provided to appropriate staff. On July 24, 2014, the Chief, Radiology Service and the ACOS, Education Service met with the MRI Safety Committee and identified personnel needing MRI safety training based on position. Employees from Environmental Management Service (EMS), Engineering, Police, and Nursing Services were selected for the Level 1 training. A total of 448 employees were assigned the annual training in TMS, the electronic education system. To date, 418 (93 percent) have completed the course.

Effective February 2015 the training compliance rate will be added to the MRI Safety Committee agenda as a metric to be discussed at each meeting. As the facility strives for full compliance, the Committee will work with Education Service to send reminders to Service Chiefs with employees required to have the annual safety training so managers can monitor compliance. At any time MRI personnel can request evidence of the completed training. MRI personnel are aware of training requirements and will not allow untrained individuals into the designated Zone 3.

Recommendation 17. We recommended that the facility develop and implement an acute ischemic stroke policy that addresses all required items.

Concur

Target date for completion: January 31, 2015

Facility response: The facility acute ischemic stroke policy has been sent to Chief of Staff for final review and approval. It addresses all required items. It should be approved by Jan 15, 2015. The Assistant Chief, Neurology Service will ask the ACOS, Education to forward copies of the facility policy to all clinicians upon approval. The Chief, ED will review the policy with ED staff, and the Assistant Chief, Neurology Service will review the policy with Neurology staff in staff meetings.

Recommendation 18. 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: March 31, 2015

Facility response: All neurology residents are currently certified to perform NIH Stroke Scale (NIHSS) evaluations. The Assistant Chief, Neurology Service will educate the residents that the NIHSS score must be entered into their first patient note. The Chief, ED will train and certify appropriate ED staff in NIHSS for use in all suspected stroke patients by January 31, 2015. The Neurology Service RN will monitor NIHSS documentation at stroke presentation and educate the physician(s) when it is omitted. The RN will compile monthly documentation data for the monthly Stroke Committee to review to ensure ongoing compliance with appropriate documentation.

Recommendation 19. We recommended that facility managers post stroke guidelines in all areas where patients may present with stroke symptoms.

Concur

Target date for completion: January 31, 2015

Facility response: The Stroke Committee is responsible for ensuring the acute ischemic stroke (AIS) guidelines are posted in all areas where patients may present with stroke

symptoms. The Chair, Stroke Committee will oversee posting the guidelines for the management of AIS in the ED, clinic areas, at the CBOCs, and on all medical/surgical nursing units.

Recommendation 20. We recommended that clinicians screen patients for difficulty swallowing prior to oral intake and that facility managers monitor compliance.

Concur

Target date for completion: March 31, 2015

Facility response: The neurology residents will be educated by the Assistant Chief, Neurology Service to include a sip test assessment in their notes whenever they see a suspected stroke. The ED staff will be similarly trained by the Chief, ED. Training will be completed by Jan 31, 2015. The Neurology Service RN will monitor "sip testing" documentation in CPRS by physicians or other medical personnel. The RN will compile monthly documentation data for the Stroke Committee to review to ensure ongoing compliance with appropriate documentation.

Recommendation 21. 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: January 31, 2015

Facility response: The process has been defined how the data for the stroke quality measures will be collected and reported. The Neurology Service RN will contact the Neurology Chief Resident on a daily basis to identify new stroke patients and whether they were eligible for tPA. The RN will collect the three quality measures (mentioned in the recommendation) and present aggregate data to the Stroke Committee monthly meeting (2 PM, second Thursday of each month, in Neurology Conference room). Data collection will begin January 2015. A schedule is being defined to present this data to the facility Clinical Executive Board. As appropriate, data will be reported to the VHA.

Recommendation 22. We recommended that facility managers ensure that nursing staff who perform 12-lead electrocardiograms have a current competency assessment and validation included in their competency checklists and have competency assessment and validation documentation completed.

Concur

Target date for completion: Completed

Facility response: Nursing Service has provided competency training and check-off on all nursing staff that work with telemetry patients and/or perform 12-lead EKG in the inpatient areas of the hospital. The competency check list for 12-lead EKG is in each employee folder. This was completed December 16, 2014.

Recommendation 23. We recommended that facility managers ensure post-anesthesia care competency assessment and validation is included in competency checklists for employees on the post-anesthesia care unit.

Concur

Target date for completion: Completed

Facility response: All post-anesthesia room nursing staff has had all of their annual competencies completed and updated as of December 16, 2014. Nursing Service has also set up a tracking system to assure competency maintenance in each clinical area.

Recommendation 24. We recommended that the facility revise the emergency airway management policy to include all required Veterans Health Administration elements.

Concur

Target date for completion: January 15, 2015

Facility response: The Out of OR Airway Management (OOORAM) policy has been revised to include all required elements of the VHA directive. The policy is in the final stages of medical staff approval.

Recommendation 25. We recommended that the facility ensure clinician reassessment for continued emergency airway management competency includes all required subject matter content elements and a written exam and that facility managers monitor compliance.

Concur

Target date for completion: Completed

Facility response: The revised OOORAM policy includes the requirement that all staff involved in airway management meet criteria for ongoing demonstration of competency in the four basic modalities of airway management, complete the competency based annual written examination, and meet a minimum number of live intubations in order to be designated as airway officers. This requirement applies to all airway management officers including physicians. The Chief, Anesthesiology Service has oversight for the cognitive and procedural skills assessment and the Out of OR Template data, tracking and trending compliance. The Chief, Anesthesiology Service monitors compliance with completion of required training. Data will be presented to the local Clinical Executive Board (CEB) quarterly.

Recommendation 26. We recommended that the facility ensure that clinician reassessment for continued emergency airway management competency includes evidence of successful demonstration of all required procedural skills on airway simulators or mannequins and that facility managers monitor compliance.

Concur

Target date for completion: Completed

Facility response: The revised OOORAM policy includes all components of this OIG Recommendation as a requirement. Currently, all designated first-line airway management personnel (airway officers) have undergone this hands-on demonstration of procedural skills under the supervision of the Chief, Anesthesiology Service. As per the revised EAM policy, demonstration of procedural skills is an annual requirement for airway officers. The Chief, Anesthesiology Service has oversight for the cognitive and procedural skills assessment and tracking compliance.

Recommendation 27. We recommended that facility managers ensure video laryngoscopes are available in all designated locations and monitor compliance.

Concur

Target date for completion: February 1, 2015

Facility response: Video laryngoscopes and portable end tidal CO2 monitors have been secured and assigned to designated areas within the facility allowing for immediate availability for airway emergencies. Currently, the designated locations for video laryngoscopes that are available for emergency use are the ED, Respiratory Therapy Department, and Anesthesiology Service. Release for patient care use is pending nursing competency training on maintenance of the equipment. Projected training completion date is February 1, 2015. The Chief, Anesthesiology Service will receive a report on January 28 to verify the status of training completion to ensure 100 percent training is completed by February 1.

Office of Inspector General
Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the OIG at (202) 461-4720.
Inspection Team	Lauren Olstad, MSW, LCSW, Team Leader Darlene Conde-Nadeau, MSN, ARNP David Griffith, BS, RN Martha A. Kearns, MSN, FNP Alice Morales-Rullan, MSN, RN Carol Torczon, MSN, ACNP Brian Celatka, Resident Agent in Charge, Office of Investigations
Other Contributors	Elizabeth Bullock Shirley Carlile, BA Paula Chapman, CTRS Lin Clegg, PhD Marnette Dhooghe, MS Karen McGoff-Yost, MSW, LCSW Patrick Smith, M. Stat Julie Watrous, RN, MS Jarvis Yu, MS

Report Distribution

VA Distribution

Office of the Secretary
Veterans Health Administration
Assistant Secretaries
General Counsel
Director, VA Mid South Healthcare Network (10N9)
Director, Memphis VA Medical Center (614/00)

Non-VA Distribution

House Committee on Veterans' Affairs
House Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
House Committee on Oversight and Government Reform
Senate Committee on Veterans' Affairs
Senate Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
Senate Committee on Homeland Security and Governmental Affairs
National Veterans Service Organizations
Government Accountability Office
Office of Management and Budget
U.S. Senate: Lamar Alexander, John Boozman, Thad Cochran, Bob Corker, Tom Cotton, Mitch McConnell, Rand Paul, Roger F. Wicker
U.S. House of Representatives: Marsha Blackburn, Steve Cohen, Rick Crawford, Stephen Fincher, Alan Nunnelee, Bennie G. Thompson, Ed Whitfield

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

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, VA Master Specifications.

[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] 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.

[f] 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.

[g] 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.

[h] 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.