Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 14-04224-107

Combined Assessment Program Review of the Erie VA Medical Center Erie, Pennsylvania

February 10, 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
EHR	electronic health record
EOC	environment of care
facility	Erie VA Medical Center
FY	fiscal year
MH	mental health
NA	not applicable
NM	not met
OIG	Office of Inspector General
QM	quality management
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Table of Contents

Executive Summary

Review Purpose: The purpose of the review was to evaluate selected health care facility operations, focusing on patient care quality and the environment of care, and to provide crime awareness briefings. We conducted the review the week of December 1, 2014.

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

- Environment of Care
- Medication Management

The facility's reported accomplishment was expanding telehealth and home-based primary care programs.

Recommendations: We made recommendations in the following four activities:

Quality Management: Monitor the recently revised reprivileging process to ensure practitioners have the appropriate skills and training for emergency airway management. Ensure the Safe Patient Handling Committee gathers, tracks, and shares patient handling injury data.

Coordination of Care: Ensure Medicine Service designates an Automated Data Processing Applications Coordinator.

Acute Ischemic Stroke Care: Provide printed stroke education to patients upon discharge.

Emergency Airway Management: Ensure initial clinician emergency airway management competency assessment includes all required elements.

Comments

The Acting Veterans Integrated Service Network Director and Facility Director agreed with the Combined Assessment Program review findings and recommendations and provided acceptable improvement plans. (See Appendixes C and D, pages 21–24, for the full text of the Directors' comments.) We will follow up on the planned actions until they are completed.

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

Objectives and Scope

Objectives

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

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

Scope

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

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

- QM
- EOC
- Medication Management
- Coordination of Care
- Acute Ischemic Stroke Care
- 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 December 1, 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 Erie VA Medical Center, Erie, Pennsylvania, Report No. 12-01334-261, September 4, 2012).

During this review, we presented crime awareness briefings for 79 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 207 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 Accomplishment

Expanding Telehealth and Home-Based Primary Care Programs

For easier access to follow-up care, the facility started the first telecardiac rehabilitation program in VISN 4 in 2014. Patients using this program visit their VA clinic at least once for an initial visit. A physical therapist from the facility then follows the patient at home through video conferencing. Additionally, the facility is piloting a collaborative telehealth effort with a local university where telebehavioral health programs will be offered on campus. The facility also expanded home-based primary care to patients living in rural areas after hiring two additional nurses for the program.

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, six credentialing and privileging folders, 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.		
	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.	• Of the six licensed independent practitioners' folders reviewed, five did not contain all elements needed for EAM privileges. The facility recently revised their EAM reprivileging process to align with current VHA policy.	**1.** We recommended that facility managers monitor the recently revised reprivileging process to ensure practitioners have the appropriate skills and training for emergency airway management.
	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
NA	The surgical review process met selected requirements: • An interdisciplinary committee with appropriate leadership and clinical membership met monthly to review surgical processes and outcomes. • 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.		
X	The safe patient handling program met selected requirements: • A committee provided program oversight. • The committee gathered, tracked, and shared patient handling injury data.	Twelve months of Safe Patient Handling Committee meeting minutes reviewed: • The committee did not gather, track, and share patient handling injury data.	**2.** We recommended that the Safe Patient Handling Committee gather, track, and share 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 the CLC.[b]

We inspected the dental, eye, MH, podiatry, primary care, urgent care, urology, and women's health clinics; the same day surgery area; the medical inpatient unit; and both CLCs. Additionally, we reviewed relevant documents and 20 CLC employee training records, and we conversed with key employees and managers. 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 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.		
	Selected employees received training on updated requirements regarding chemical labeling and safety data sheets.		
	The facility met fire safety requirements.		
	The facility met environmental safety requirements.		
	The facility met infection prevention requirements.		

NM	Areas Reviewed for General EOC (continued)	Findings	Recommendations
	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		
NA	Designated critical care employees received bloodborne pathogens training during the past 12 months.		
NA	Alarm-equipped medical devices used in critical care were inspected/checked according to local policy and/or manufacturers' recommendations.		
NA	The facility met fire safety requirements in critical care.		
NA	The facility met environmental safety requirements in critical care.		
NA	The facility met infection prevention requirements in critical care.		
NA	The facility met medication safety and security requirements in critical care.		
NA	The facility met medical equipment requirements in critical care.		
NA	The facility met privacy requirements in critical care.		
NA	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.		

NM	Areas Reviewed for CLC	Findings	Recommendations
	Designated CLC employees received bloodborne pathogens training during the past 12 months.		
	For CLCs with resident animal programs, the facility conducted infection prevention risk assessments and had policies addressing selected requirements.		
	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.		
	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 20 nursing employees, and pharmacy monthly medication storage area inspection documentation for the past 6 months. Additionally, we inspected the urgent care clinic, two CLCs, and the medical inpatient unit and for these areas reviewed documentation of overrides and narcotic wastage from automated dispensing machines and inspected crash carts containing emergency medications. 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 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 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 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.		
	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.		
	The facility employed practices to prevent wrong-route drug errors.		
	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 37 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	Finding	Recommendation
	A committee oversaw the facility's consult management processes.		
X	Major bed services had designated employees to: • Provide training in the use of the computerized consult package • Review and manage consults	• Medicine Service did not have an Automated Data Processing Applications Coordinator.	**3.** We recommended that Medicine Service designate an Automated Data Processing Applications Coordinator.
	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.		
	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, the EHRs of 19 patients who experienced stroke symptoms, and 35 employee training records (20 urgent care clinic, 10 medical inpatient unit, and 5 CLC), and we conversed with key employees. We also conducted onsite inspections of the urgent care clinic, the medical inpatient unit, and two CLC units. 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	Finding	Recommendation
	The facility's stroke policy addressed all required items.		
	Clinicians completed the National Institutes of Health stroke scale for each patient within the expected timeframe.		
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.		
	Clinicians screened patients for difficulty swallowing prior to oral intake of food or medicine.		
X	Clinicians provided printed stroke education to patients upon discharge.	• Clinicians did not document in either of the two applicable patients' EHRs that they provided stroke education to the patients/caregivers.	**4.** We recommended that clinicians provide printed stroke education to patients upon discharge and that facility managers monitor compliance.
	The facility provided training to employees involved in assessing and treating stroke patients.		

NM	Areas Reviewed (continued)	Finding	Recommendation
	The facility collected and reported required data related to stroke care.		
	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.[f]

We reviewed relevant documents, including competency assessment documentation of six 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.

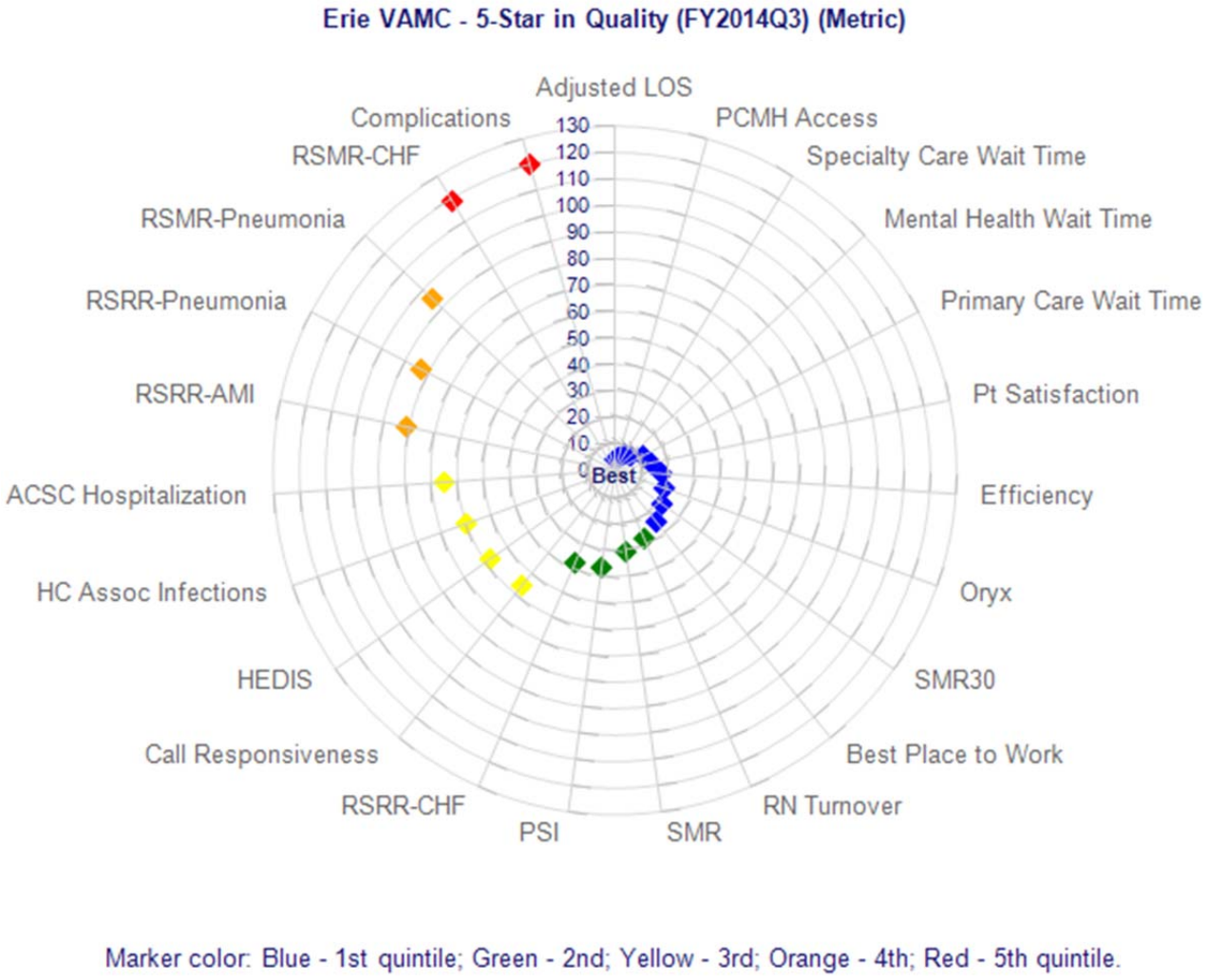
NM	Areas Reviewed	Findings	Recommendations
	The facility had a local EAM policy or had a documented exemption.		
NA	If the facility had an exemption, it did not have employees privileged to perform procedures using moderate or deep sedation that might lead to airway compromise.		
	Facility policy designated a clinical subject matter expert, such as the Chief of Staff or Chief of Anesthesia, to oversee EAM.		
	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		
X	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	• None of the three clinicians with initial EAM competency assessment had documentation of any of the required elements.	**5.** We recommended that the facility ensure initial clinician emergency airway management competency assessment includes all required elements and that facility managers monitor compliance.

NM	Areas Reviewed (continued)	Findings	Recommendations
	• 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	• Two of the three clinicians with reassessments for continued EAM competency did not have evidence of successful demonstration of all airway management and intubation skills to the facility subject matter expert prior to their first assigned coverage during our review period. The facility recently revised their EAM reprivileging process to align with current VHA policy.	See recommendation 1.
	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.		
	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.		

Facility Profile (Erie/562) FY 2015 through December 2014[1]	
Type of Organization	Secondary
Complexity Level	3-Low complexity
Affiliated/Non-Affiliated	Affiliated
Total Medical Care Budget in Millions	$102.8
Number of:	
• **Unique Patients**	14,479
• **Outpatient Visits**	51,439
• **Unique Employees**[2]	533
Type and Number of Operating Beds (as of November):	
• **Hospital**	21
• **CLC**	39
• **MH**	NA
Average Daily Census (as of November):	
• **Hospital**	3
• **CLC**	32
• **MH**	NA
Number of Community Based Outpatient Clinics	5
Location(s)/Station Number(s)	Meadville/562GA Ashtabula/562GB Bradford/562GC Franklin/562GD Warren/562GE
VISN Number	4

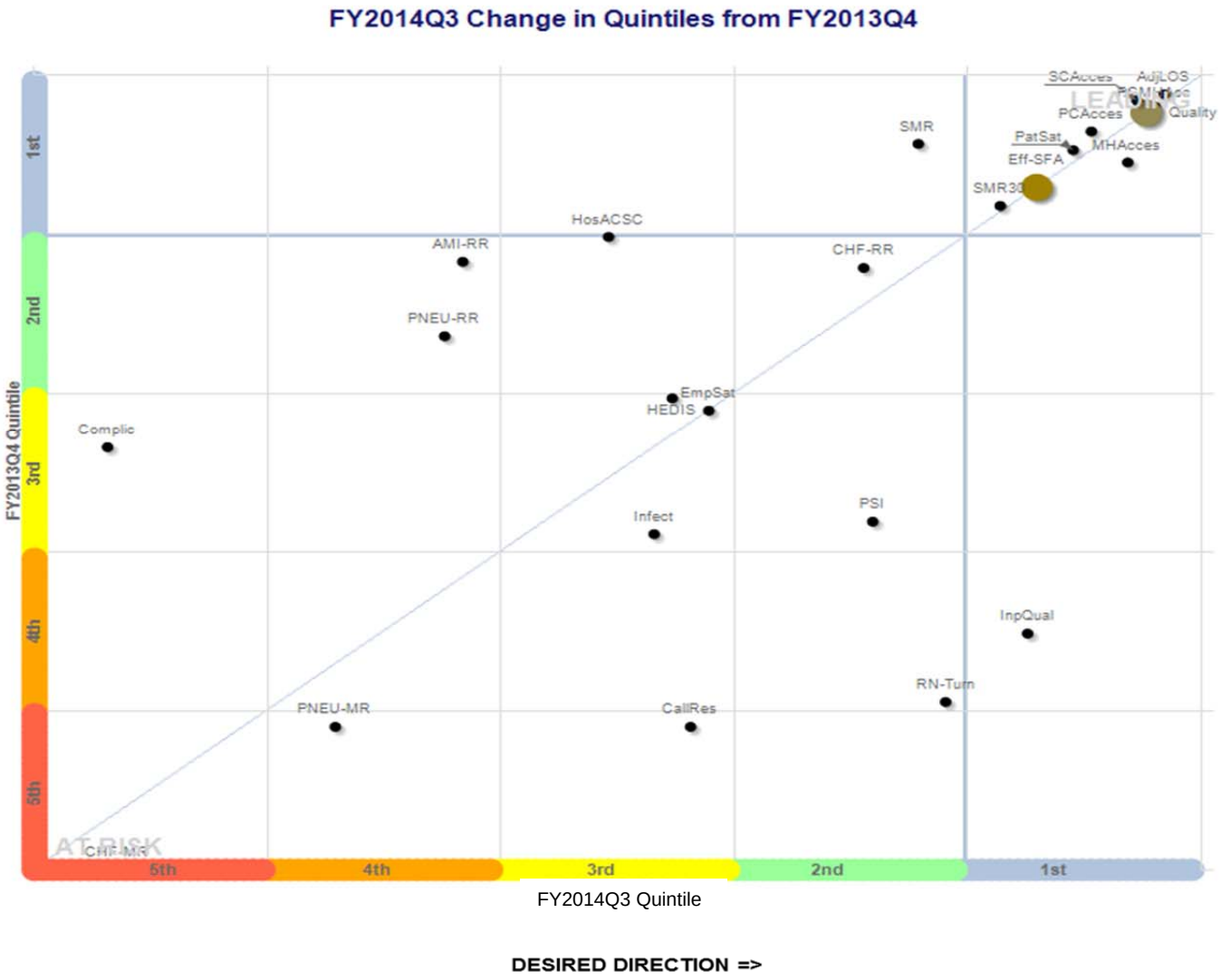
[1] All data is for FY 2015 through December 2014 except where noted.
[2] Unique employees involved in direct medical care (cost center 8200) from most recent pay period.

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



[3] Metric definitions follow the graphs.

Scatter Chart



NOTE

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

Metric Definitions

Measure	Definition	Desired direction
ACSC Hospitalization	Ambulatory care sensitive condition hospitalizations (observed to expected ratio)	A lower value is better than a higher value
Adjusted LOS	Acute care risk adjusted length of stay	A lower value is better than a higher value
Best Place to Work	Overall satisfaction with job	A higher value is better than a lower value
Call Center Responsiveness	Average speed of call center responded to calls in seconds	A lower value is better than a higher value
Call Responsiveness	Call center speed in picking up calls and telephone abandonment rate	A lower value is better than a higher value
Complications	Acute care risk adjusted complication ratio	A lower value is better than a higher value
Efficiency	Overall efficiency measured as 1 divided by SFA (Stochastic Frontier Analysis)	A higher value is better than a lower value
Employee Satisfaction	Overall satisfaction with job	A higher value is better than a lower value
HC Assoc Infections	Health care associated infections	A lower value is better than a higher value
HEDIS	Outpatient performance measure (HEDIS)	A higher value is better than a lower value
MH Status	MH status (outpatient only, the Veterans RAND 12 Item Health Survey)	A higher value is better than a lower value
MH Wait Time	MH wait time for new and established patients (top 50 clinics; FY13 and later)	A higher value is better than a lower value
Oryx	Inpatient performance measure (ORYX)	A higher value is better than a lower value
Physical Health Status	Physical health status (outpatient only, the Veterans RAND 12 item Health Survey)	A higher value is better than a lower value
Primary Care Wait Time	Primary care wait time for new and established patients (top 50 clinics; FY13 and later)	A higher value is better than a lower value
PSI	Patient safety indicator (observed to expected ratio)	A lower value is better than a higher value
Pt Satisfaction	Overall rating of hospital stay (inpatient only)	A higher value is better than a lower value
RN Turnover	Registered nurse turnover rate	A lower value is better than a higher value
RSMR-AMI	30-day risk standardized mortality rate for acute myocardial infarction	A lower value is better than a higher value
RSMR-CHF	30-day risk standardized mortality rate for congestive heart failure	A lower value is better than a higher value
RSMR-Pneumonia	30-day risk standardized mortality rate for pneumonia	A lower value is better than a higher value
RSRR-AMI	30-day risk standardized readmission rate for acute myocardial infarction	A lower value is better than a higher value
RSRR-CHF	30-day risk standardized readmission rate for congestive heart failure	A lower value is better than a higher value
RSRR-Pneumonia	30-day risk standardized readmission rate for pneumonia	A lower value is better than a higher value
SMR	Acute care in-hospital standardized mortality ratio	A lower value is better than a higher value
SMR30	Acute care 30-day standardized mortality ratio	A lower value is better than a higher value
Specialty Care Wait Time	Specialty care wait time for new and established patients (top 50 clinics; FY13 and later)	A higher value is better than a lower value

Acting VISN Director Comments

Department of Veterans Affairs

Memorandum

Date: January 20, 2015

From: Interim Network Director, VA Healthcare – VISN 4 (10N4)

Subject: **CAP Review of the Erie VA Medical Center, Erie, PA**

To: Director, Baltimore Office of Healthcare Inspections (54BA)

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

1. I have reviewed the response provided by the Erie VA Medical Center and I am submitting to your office as requested. I concur with all responses.

2. If you have any questions or require additional information, please contact Moira Hughes, Acting VISN 4 Quality Management officer at 412-822-3294.

Carla A. Sivek
Acting VISN 4 Network Director

Attachment

Facility Director Comments

Department of Veterans Affairs

Memorandum

Date: January 14, 2015

From: Director, Erie VA Medical Center (562/00)

Subject: **CAP Review of the Erie VA Medical Center, Erie, PA**

To: Director, VA Healthcare – VISN 4 (10N4)

1. I have reviewed the draft report of the Inspector General Combined Assessment Program Review of the Erie VA Medical Center. I concur with the findings outlined in this report and have included corrective action plans for each recommendation.

X

David Cord

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 monitor the recently revised reprivileging process to ensure practitioners have the appropriate skills and training for emergency airway management.

Concur

Target date for completion: April 15, 2015

Facility response: All six practitioners are in compliance with required training/skills to be granted the privilege for Out of Operating Room (OR) Airway Management according to the June 1, 2013 facility Medical Center Memorandum 11-16 Emergency Airway Management. The Chief of Staff Office will continue to track initial and renewal competency requirements for all physicians with the Out-of-OR-Airway management privilege. Two tracking spreadsheets have been created for tracking initial and renewal of the Out-of-OR-Airway management privilege. Appropriate skills and training for practitioners in emergency airway management will be tracked for three months with a target of 100% compliance.

Recommendation 2. We recommended that the Safe Patient Handling Committee gather, track, and share patient handling injury data.

Concur

Target date for completion: March 1, 2015

Facility response: The Safe Patient Handling Committee tracks and shares data related to patient handling injuries. The patient handling injury topic was added to the Safe Patient Handling Committee agenda and will be documented in the meeting minutes beginning on February 5, 2015. The meeting minutes will be reviewed and signed by the Chief, Nursing Services and Associate Director, Patient Care Services.

Recommendation 3. We recommended that Medicine Service designate an Automated Data Processing Applications Coordinator.

Concur

Target date for completion: March 1, 2015

Facility response: The Chief, Clinical Services began recruitment for a Primary Care Management Module (PCMM) Coordinator position on January 7, 2015 to assist with

Automated Data Processing Applications Coordinator (ADPAC) coordination for Medicine. The current Clinical Services Secretary has ADPAC capability and handles the following ADPAC responsibilities: requests the creation of VISTA accounts, electronic signature code and block, ensures user agreements are signed, and assigns appropriate menus, security keys, user classes, person classes, and mail groups to users with the service.

Recommendation 4. We recommended that clinicians provide printed stroke education to patients upon discharge and that facility managers monitor compliance.

Concur

Target date for completion: April 15, 2015

Facility response: Inpatient nursing staff was educated regarding the importance of education throughout the hospital stay for patients admitted for post-stroke care during unit huddles and email. The patient educational resources for stroke care located on the CPRS tool bar were reviewed with staff during huddles and email. Staff acknowledgement and understanding of the training was documented by 12/31/2014. Nursing education templates for Nursing Inpatient Note and Nursing Discharge Summary Note were modified to include selections for specific written stroke and cardiovascular education and instructions so that nursing documentation of the patient education is provided and documented during the patient's hospitalization and upon discharge. All medical records of patients admitted to the acute inpatient care unit for post-stroke care will be audited for three months by the Acute Care Nursing Supervisor for documentation of written discharge stroke education. Target for compliance is 100%. Audit results will be reported on the Nurse Executive Balanced Scorecard monthly and to the Nurse Executive Council.

Recommendation 5. We recommended that the facility ensure initial clinician emergency airway management competency assessment includes all required elements and that facility managers monitor compliance.

Concur

Target date for completion: April 15, 2015

Facility response: The current Medical Center Memorandum 11-16 Emergency Airway Management, dated June 1, 2013, addresses the minimal procedural skills that must be demonstrated during the initial and re-assessment of emergency airway management privileges. The Chief of Staff Office conducted a review of the credentialing and privileging records of practitioners to ensure that initial assessment and re-assessment of emergency airway management was documented according to the policy. There is documentation to support that all providers have completed the Talent Management System (TMS) module, Out of OR Airway Management, and all have completed SIM-Lab training with the Staff Anesthesiologist. The Chief of Staff Office will continue to monitor initial and renewal competency requirements for all physicians with the Out-of-OR-Airway Management privilege for three months for 100% compliance.

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	Jennifer Christensen, DPM, Team Leader Michael Bishop, MSW Alison Loughran, JD, RN Melanie Oppat, MEd, LDN Margie Chapin, RT (R, MR, CT), JD Timothy Barry, Resident Agent in Charge
Other Contributors	Elizabeth Bullock Shirley Carlile, BA Paula Chapman, CTRS Lin Clegg, PhD Marnette Dhooghe, MS Terri Julian, Ph.D Patrick Smith, M. Stat Julie Watrous, RN, MS Jarvis Yu, MS

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U.S. Senate: Sherrod Brown; Robert P. Casey, Jr.; Rob Portman; Patrick J. Toomey
U.S. House of Representatives: David Joyce, Mike Kelly, Glenn W. Thompson

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.

[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 2012-032, *Out of Operating Room Airway Management*, October 26, 2012.
- VHA Handbook 1101.04, *Medical Officer of the Day*, August 30, 2010.