Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 14-04222-141

Combined Assessment Program Review of the VA Roseburg Healthcare System Roseburg, Oregon

March 4, 2015

Washington, DC 20420

To Report Suspected Wrongdoing in VA Programs and Operations
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Glossary

CAP	Combined Assessment Program
CLC	community living center
CRC	colorectal cancer
EAM	emergency airway management
EHR	electronic health record
EOC	environment of care
facility	VA Roseburg Healthcare System
FPPE	Focused Professional Practice Evaluation
FY	fiscal year
MH	mental health
MRI	magnetic resonance imaging
NA	not applicable
NM	not met
OIG	Office of Inspector General
QM	quality management
RRTP	residential rehabilitation treatment program
VHA	Veterans Health Administration

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Executive Summary

Review Purpose: The purpose of the review was to evaluate selected health care facility operations, focusing on patient care quality and the environment of care. We conducted the review the week of November 17, 2014.

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

- Environment of Care

The facility's reported accomplishment was the development of Nutrition-Patient Aligned Care Team Diabetes Women's Shared Medical Appointment and Telehealth group clinics to provide comprehensive diabetes care to women veterans.

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

Quality Management: Comply with Veterans Health Administration requirements for credentialing and privileging, utilization management, review of resuscitation, patient safety, and electronic health records review.

Medication Management: Revise the policy for safe use of automated dispensing machines to include employee training and minimum competency requirements for users.

Coordination of Care: Designate Automated Data Processing Applications Coordinators to train employees and to manage, implement, and maintain the computerized consult package.

Magnetic Resonance Imaging Safety: Conduct cardiac arrest, contrast reaction, and fire emergency drills in magnetic resonance imaging. Require Level 2 magnetic resonance imaging personnel and/or radiologists to document resolution of all identified contraindications prior to completing the scan. Ensure all designated Level 1 ancillary staff and Level 2 magnetic resonance imaging personnel receive required training annually. Regularly test the two-way communication device. Review and update local magnetic resonance imaging policies in accordance with facility policy.

Acute Ischemic Stroke Care: Revise the acute ischemic stroke policy to include all required elements. Complete and document National Institutes of Health stroke scales for each stroke patient. Post stroke guidelines in the Emergency Department and community living center and on all inpatient units. Screen patients for difficulty swallowing prior to oral intake. Provide printed stroke education to patients at discharge. Provide a stroke education program for employees who assess and treat stroke patients.

Mental Health Residential Rehabilitation Treatment Program: Conduct and document monthly domiciliary self-inspections that include all required elements, submit work orders for items needing repair, and correct any identified deficiencies. Perform and document contraband inspections, rounds of all public spaces, and inspections for unsecured medications. Require written agreements acknowledging resident responsibility for medication security. Install closed circuit television with recording capabilities in all domiciliary public areas.

Emergency Airway Management: Revise the emergency airway management (EAM) policy to include a plan for managing a difficult airway. Include all required elements in clinician initial assessment and reassessment for EAM competency. Ensure that clinician reassessment for EAM competency includes reviews of clinician-specific EAM data and that clinicians reassessed for continued EAM scope of practice have a statement related to EAM in the scope of practice. Ensure a clinician with EAM privileges or scope of practice is available during all hours the facility provides patient care. Require that Emergency Department clinicians and clinicians with moderate sedation privileges have EAM privileges. Strengthen processes to minimize a repeat occurrence in which non-privileged providers perform intubations, and in instances of occurrence, initiate root cause analyses. Report EAM data quarterly.

Follow-Up on Quality Management: Report Focused Professional Practice Evaluation results for all newly hired licensed independent practitioners to the Medical Executive Committee. Ensure the Medical Records Committee monitors the copy and paste functions.

Follow-Up on Colorectal Cancer Screening: Notify patients of positive screening and diagnostic test results within the required timeframe, and document notification. Develop follow-up plans or document that no follow up is indicated within the required timeframe.

Comments

The Veterans Integrated Service Network and Interim Facility Director agreed with the Combined Assessment Program review findings and recommendations and provided acceptable improvement plans. (See Appendixes C and D, pages 29–44, for the full text of the Directors' comments.) We will follow up on the planned actions until they are completed.

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Objective and Scope

Objective

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 objective of the CAP review is to:

- Conduct recurring evaluations of selected health care facility operations, focusing on patient care quality and the EOC.

Scope

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

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

- QM
- EOC
- Medication Management
- Coordination of Care
- MRI Safety
- Acute Ischemic Stroke Care
- MH RRTP
- EAM
- Follow-Up on QM
- Follow-Up on CRC Screening

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

The review covered facility operations for FY 2013, FY 2014, and FY 2015 through November 20, 2014, and was done in accordance with OIG standard operating procedures for CAP reviews. We also asked the facility to provide the status on the recommendations we made in our previous CAP report (*Combined Assessment Program Review of the VA Roseburg Healthcare System, Roseburg, Oregon,* Report No. 11-03667-108, March 13, 2012). We made repeat recommendations in QM and CRC screening.

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 208 responded. We shared summarized results with the Interim Facility Director.

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

Nutrition-Patient Aligned Care Team Diabetes Women's Shared Medical Appointment and Telehealth Group Clinics

The Nutrition-Patient Aligned Care Team Diabetes Women's Shared Medical Appointment and Telehealth group clinics were created in 2014 to provide comprehensive diabetes care to women veterans. The program serves veterans at the facility and in outlying communities. Veterans living in rural areas have been able to participate through community based outpatient clinics via telehealth technology. Certified Diabetes Educators® conduct classes using the U.S. Diabetes *Conversation Map*.® This innovative self-management tool provides an interactive experience. Using a mobile teaching kitchen reinforces principles through live cooking demonstrations. Participants learn all aspects of diabetes self-management from expert instructors, gaining information they can use to prevent diabetes complications. A specially trained clinician administers continuous glucose monitoring to those requiring intensive treatment.

The data collected from the program has shown improved access and quality of care for veterans. Health improvements include decreases in body mass index, hemoglobin A1c, low-density lipoprotein cholesterol, and blood pressure levels. Pre- and post-test evaluations have demonstrated that veterans increased their knowledge of diabetes self-management.

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, 11 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.	• Facility managers did not review privilege forms annually. • In all 11 licensed independent practitioners' folders reviewed, practitioners' privileges were not appropriate for their skills and training.	**1.** We recommended that facility managers review privilege forms annually and document the review. **2.** We recommended that facility managers ensure that privileges granted are appropriate for the practitioners' skills and training.
X	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.	Nine months of data reviewed: • For January through September 2014, the facility converted 38 percent of observation patients to acute admissions but did not reassess observation criteria or utilization during that time.	**3.** We recommended that when conversions from observation bed status to acute admissions are 25–30 percent or more, the facility reassess observation criteria and utilization.
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 Acute Care Advisory Board meeting minutes reviewed: • The committee did not review each episode. • Code reviews did not include screening for clinical issues prior to the code that may have contributed to the occurrence of the code.	**4.** We recommended that the Acute Care Advisory Board review each code episode and that code reviews include screening for clinical issues prior to the code that may have contributed to the occurrence of the code.

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.		
X	Clinicians appropriately reported critical incidents.	• The recipient list for the automatic e-mail notification was not current.	**5.** We recommended that the facility keep the recipient list for the automated e-mail notification current.
	The safe patient handling program met selected requirements: • A committee provided program oversight. • The committee gathered, tracked, and shared patient handling injury data.		
X	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.	Twelve months of EHR Committee meeting minutes reviewed: • The committee analyzed EHR quality data for only 1 quarter. • The review of EHR quality did not include EHRs from services such as MH, Primary Care, and Acute Medical Care. This was a repeat finding from the previous CAP review.	**6.** We recommended that the facility analyze electronic health record data at least quarterly and include most services in the review of electronic health record quality.

NM	Areas Reviewed (continued)	Findings	Recommendations
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. • 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.	• There was no process for the destruction of original documents.	**7.** We recommended that the facility implement a process for the destruction of original 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.		
X	The facility met any additional elements required by VHA or local policy.	Facility policy on safe patient handling requires quarterly reporting of patient handling incident data. Twelve months of Safe Patient Handling Committee meeting minutes reviewed: • Only one quarter of patient handling injury data was reported.	**8.** We recommended that the Safe Patient Handling Committee report patient handling injury data quarterly.

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 Emergency Department, the inpatient medical/surgical and MH units, the primary care outpatient clinics, and the CLC. Additionally, we reviewed relevant documents and 10 CLC employee training records and 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 Emergency Department, the inpatient medical/surgical unit, the post-anesthesia care unit, and the CLC and for these areas reviewed documentation of narcotic wastage from automated dispensing machines and inspected crash carts containing emergency medications. The table below shows the areas reviewed for this topic. The area marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

NM	Areas Reviewed	Findings	Recommendations
	Facility policy addressed medication receipt in patient care areas, storage procedures until administration, and staff authorized to have access to medications and areas used to store them.		
	The facility required two signatures on controlled substances partial dose wasting.		
	The facility defined those medications and supplies needed for emergencies and procedures for crash cart checks, checks included all required elements, and the facility conducted checks with the frequency required by local policy.		
	The facility prohibited storage of potassium chloride 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/storage processes to prevent errors.		
	The facility identified in writing its high-alert and hazardous medications, ensured the high-alert list was available for staff reference, and had processes to manage these medications.		
	The facility conducted and documented inspections of all medication storage areas at least every 30 days, fully implemented corrective actions, and monitored the changes.		
X	The facility/Pharmacy Service had a written policy for safe use of automated dispensing machines that included oversight of overrides and employee training and minimum competency requirements for users, and employees received training or competency assessment in accordance with local policy.	• Facility policy for safe use of automated dispensing machines did not include employee training and minimum competency requirements for users.	**9.** We recommended that the facility revise the policy for safe use of automated dispensing machines to include employee training and minimum competency requirements for users and that facility managers monitor compliance.
	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.		

NM	Areas Reviewed (continued)	Findings	Recommendations
	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.		
X	Major bed services had designated employees to: • Provide training in the use of the computerized consult package • Review and manage consults	• None of the service lines had Automated Data Processing Applications Coordinators. • The facility did not have a person or process to provide training in the use of the computerized consult package.	**10.** We recommended that the facility designate Automated Data Processing Applications Coordinators to train employees and to manage, implement, and maintain the computerized consult package.
	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.		

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) employee safety training, (2) patient screening, and (3) risk assessment of the MRI environment.[e]

We reviewed relevant documents and the training records of 37 employees (29 randomly selected Level 1 ancillary staff and eight 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 a physical inspection of the MRI area. The table below shows the areas reviewed for this topic. The areas marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

NM	Areas Reviewed	Findings	Recommendations
X	The facility completed an MRI risk assessment, had documented procedures for handling emergencies in MRI, and conducted emergency drills in the MRI area.	• The facility did not conduct cardiac arrest, contrast reaction, and fire emergency drills in the MRI area.	**11.** We recommended that the facility conduct cardiac arrest, contrast reaction, and fire emergency drills in magnetic resonance imaging and that facility managers monitor compliance.
	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.		
X	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.	• Twenty-one of the 23 applicable EHRs did not contain documentation that a Level 2 MRI personnel and/or radiologist addressed all identified contraindications prior to MRI.	**12.** We recommended that Level 2 magnetic resonance imaging personnel and/or radiologists document resolution in patients' electronic health records of all identified magnetic resonance imaging contraindications prior to the scan and that facility managers monitor compliance.

NM	Areas Reviewed (continued)	Findings	Recommendations
X	The facility designated Level 1 ancillary staff and Level 2 MRI personnel and ensured they received level-specific annual MRI safety training.	• None of the Level 1 ancillary staff received level-specific annual MRI safety training. • Five Level 2 MRI personnel did not receive level-specific annual MRI safety training.	**13.** We recommended that the facility ensure all designated Level 1 ancillary staff and Level 2 magnetic resonance imaging personnel receive annual level-specific magnetic resonance imaging safety training and that facility managers monitor compliance.
	The facility had signage and barriers in place to prevent unauthorized or accidental access to Zones III and IV.		
X	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.	• Facility employees did not regularly test the two-way communication device.	**14.** We recommended that facility employees regularly test the two-way communication device and that facility managers monitor compliance.
	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.		
X	The facility complied with any additional elements required by VHA or local policy.	Facility policy on governing local policies reviewed, which requires that local policies are updated as needed for policy changes and reviewed at least every 3 years: • Nine of 12 local MRI policies had not been updated in response to policy changes and were not reviewed at least every 3 years.	**15.** We recommended that the facility update local magnetic resonance imaging policies for policy changes and review the policies at least every 3 years and that facility managers monitor compliance.

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 and the EHRs of 23 patients who experienced stroke symptoms, and we conversed with key employees. We also conducted onsite inspections of the CLC, the Emergency Department, and two acute inpatient units. 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's policy did not address: o Clinical protocols or pathways for identification, evaluation, and treatment of patients with signs and symptoms consistent with acute ischemic stroke o Timeliness of completion and interpretation of computed tomography scans o Emergent transfer to the nearest primary stroke center o The difference in approach to patients presenting within the facility's defined timeframe and those presenting outside the defined timeframe o Screening for difficulty swallowing prior to oral intake	**16.** We recommended that the facility revise the stroke policy to include clinical protocols or pathways, timeliness of completion and interpretation of computed tomography scans, emergent transfer to the nearest primary stroke center, the difference in approach to patients presenting within the facility's defined timeframe for tissue plasminogen activator and those presenting outside of that timeframe, and screening for difficulty swallowing prior to oral intake and that facility managers fully implement the revised policy.
X	Clinicians completed the National Institutes of Health stroke scale for each patient within the expected timeframe.	• None of the seven applicable EHRs contained documented evidence of completion of stroke scales.	**17.** We recommended that clinicians complete and document National Institutes of Health stroke scales for each stroke patient and that facility managers monitor compliance.

NM	Area Reviewed (continued)	Findings	Recommendations
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 on any unit within the facility.	**18.** We recommended that facility managers post stroke guidelines in the Emergency Department and community living center and on all inpatient units.
X	Clinicians screened patients for difficulty swallowing prior to oral intake of food or medicine.	• For six of the eight applicable patients, clinicians did not document in the EHRs that they screened the patient for difficulty swallowing prior to oral intake.	**19.** We recommended that clinicians screen patients for difficulty swallowing prior to oral intake and that facility managers monitor compliance.
X	Clinicians provided printed stroke education to patients upon discharge.	• None of the seven applicable EHRs contained documented evidence that clinicians provided stroke education to the patients/caregivers.	**20.** We recommended that clinicians provide printed stroke education to patients upon discharge and that facility managers monitor compliance.
X	The facility provided training to employees involved in assessing and treating stroke patients.	• The facility did not provide a stroke education program for employees.	**21.** We recommended that facility managers provide a stroke education program for employees who assess and treat stroke patients.
	The facility collected and reported required data related to stroke care.		
	The facility complied with any additional elements required by VHA or local policy.		

MH RRTP

The purpose of this review was to determine whether the facility's domiciliary complied with selected EOC requirements.[g]

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

NM	Areas Reviewed	Findings	Recommendations
	The residential environment was clean and in good repair.		
NA	Appropriate fire extinguishers were available near grease producing cooking devices.		
	There were policies/procedures that addressed safe medication management and contraband detection.		
X	MH RRTP employees conducted and documented monthly MH RRTP self-inspections that included all required elements, submitted work orders for items needing repair, and ensured correction of any identified deficiencies.	• We did not find documentation of monthly self-inspections.	**22.** We recommended that domiciliary employees conduct and document monthly domiciliary self-inspections that include all required elements, submit work orders for items needing repair, and ensure correction of any identified deficiencies and that domiciliary managers monitor compliance.
X	MH RRTP employees conducted and documented contraband inspections, rounds of all public spaces, daily bed checks, and resident room inspections for unsecured medications.	• Domiciliary employees did not consistently document contraband inspections, rounds of all public spaces, and inspections for unsecured medications.	**23.** We recommended that domiciliary employees perform and document contraband inspections, rounds of all public spaces, and inspections for unsecured medications and that domiciliary managers monitor compliance.
X	The MH RRTP had written agreements in place acknowledging resident responsibility for medication security.	• The domiciliary did not have written agreements in place.	**24.** We recommended that domiciliary managers ensure that written agreements are in place acknowledging resident responsibility for medication security.

NM	Areas Reviewed (continued)	Findings	Recommendations
	MH RRTP main point(s) of entry had keyless entry and closed circuit television monitoring, and all other doors were locked to the outside and alarmed.		
X	The MH RRTP had closed circuit television monitors with recording capability in public areas but not in treatment areas or private spaces and signage alerting veterans and visitors of recording.	• The domiciliary did not have closed circuit television monitoring with recording capabilities in all public areas.	**25.** We recommended that facility managers ensure that closed circuit television with recording capabilities is installed in all domiciliary public areas.
	There was a process for responding to behavioral health and medical emergencies, and MH RRTP employees could articulate the process.		
	In mixed gender MH RRTP units, women veterans' rooms had keyless entry or door locks, and bathrooms had door locks.		
	Residents secured medications in their rooms.		
	The facility complied with any additional elements required by VHA or local policy.		

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 19 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 plan for managing a difficult airway.	**26.** We recommended that the facility revise the emergency airway management policy to include 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 • Successful demonstration of procedural skills on patients	• None of the 12 clinicians with initial EAM competency assessments had documentation of all required elements.	**27.** 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
X	Reassessments for continued EAM competency were completed at the time of renewal of privileges or scope of practice and included: • Review of clinician-specific EAM data • Subject matter content elements and completion of a written test • Successful demonstration of procedural skills on airway simulators or mannequins • At least one occurrence of successful airway management and intubation in the preceding 2 years, written certification of competency by the supervisor, or successful demonstration of skills to the subject matter expert • A statement related to EAM if the clinician was not a licensed independent practitioner	• None of the seven clinicians with reassessments for continued EAM competency had clinician-specific EAM data reviewed. • None of the seven clinicians with reassessments for continued EAM competency had documentation of all required elements. • None of the seven clinicians with reassessments for continued EAM scope of practice had statements related to EAM included in the scope of practice.	**28.** We recommended that the facility ensure clinician reassessment for continued emergency airway management competency includes reviews of clinician-specific emergency airway management data and that facility managers monitor compliance. **29.** We recommended that the facility ensure clinician reassessment for continued emergency airway management competency includes all required elements and that facility managers monitor compliance. **30.** We recommended that the facility ensure that clinicians reassessed for continued emergency airway management scope of practice have a statement related to emergency airway management included in the scope of practice.
X	The facility had a clinician with EAM privileges or scope of practice available during all hours the facility provided patient care.	• None of the 30 sampled days had EAM coverage during all hours the facility provided patient care.	**31.** We recommended that the facility ensure a clinician with emergency airway management privileges or scope of practice is available during all hours the facility provides patient care and that facility managers monitor compliance.
	Video equipment to confirm proper placement of breathing tubes was available for immediate clinician use.		

NM	Areas Reviewed (continued)	Findings	Recommendations
X	The facility complied with any additional elements required by VHA or local policy.	Facility policy on EAM reviewed, which required that all Emergency Department clinicians and clinicians providing moderate sedation outside the operating room have EAM privileges, that a root cause analysis is performed when a clinician without EAM privileges performs an intubation, and that EAM data is reported quarterly to a designated committee: • Thirteen of 21 Emergency Department clinicians and clinicians with moderate sedation privileges did not have EAM privileges. • The facility had two instances when non-privileged clinicians performed intubations, and there was no documentation of a root cause analysis. • EAM data was not reported to the designated committee for 2 of 4 quarters.	**32.** We recommended that the facility ensure that all Emergency Department clinicians and clinicians with moderate sedation privileges have emergency airway management privileges. **33.** We recommended that facility managers strengthen processes to minimize a repeat occurrence in which non-privileged providers perform intubations and in instances of occurrence, initiate root cause analyses. **34.** We recommended that facility managers ensure quarterly reporting of emergency airway management data to the designated committee.

Review Activities with Previous CAP Recommendations

Follow-Up on QM

As a follow-up to recommendations from our prior CAP review, we reassessed facility compliance with FPPEs and copy and paste function monitoring.[i]

FPPE. VHA requires that the results from FPPEs be reported to the Medical Executive Committee for consideration in making the recommendation on privileges for newly hired licensed independent practitioners. The facility stated that it was not in compliance with this requirement prior to October 2014. In October 2014, the facility approved a new process for FPPEs that will ensure notification of service chiefs and administrative officers when delineation of privileges requires FPPEs. Because the new process has not been in place long enough to demonstrate sustainability, we made a repeat recommendation.

Copy and Paste Function Monitoring. VHA requires facilities to monitor the copy and paste functions in the EHR. The facility's Medical Records Committee, which monitors these functions, last reported copy and paste data at its February 2014 meeting. The committee did not meet March–September 2014; therefore, there was no evidence of copy and paste function monitoring for this timeframe.

Recommendations

35. We recommended that facility managers ensure reporting of results of completed Focused Professional Practice Evaluations for all newly hired licensed independent practitioners to the Medical Executive Committee.

36. We recommended that facility managers ensure the Medical Records Committee monitors the copy and paste functions.

Follow-Up on CRC Screening

As a follow-up to recommendations from our prior CAP review, we reassessed facility compliance with CRC screening.[j]

Positive CRC Test Result Notification. VHA requires that patients receive notification of CRC screening test results within 14 days of the laboratory receipt date for fecal occult blood tests or the test date for sigmoidoscopy or double contrast barium enema and that clinicians document notification. The facility reported collecting data for the prior 12-month period. Monthly performance varied from a low of 40 percent in July 2014 to a high of 100 percent in September 2014. The FY 2014 average for timely notification of CRC test result notification was 69 percent.

Follow-Up in Response to Positive CRC Screening Test. For any positive CRC screening test, VHA requires responsible clinicians to either document a follow-up plan or document that no follow-up is indicated within 14 days of the screening test. The facility reported collecting data for the prior 12-month period. Monthly performance varied from a low of 20 percent in July 2014 to a high of 100 percent in September 2014. The FY 2014 average for timely documented follow-up plans or documentation that no follow-up is indicated was 78 percent.

Diagnostic Test Result Notification. VHA requires communication of test results to patients no later than 14 days from the date on which the results are available to the ordering practitioner and requires clinicians to document notification. The facility reported collecting data for the prior 12-month period. Monthly performance varied from a low of 20 percent in July 2014 to a high of 100 percent in September 2014. The FY 2014 average for documentation of diagnostic test result notification to patients within the required timeframe was 61 percent.

Recommendations

37. We recommended that facility managers ensure patient notification of positive colorectal cancer screening test results within the required timeframe and that clinicians document notification.

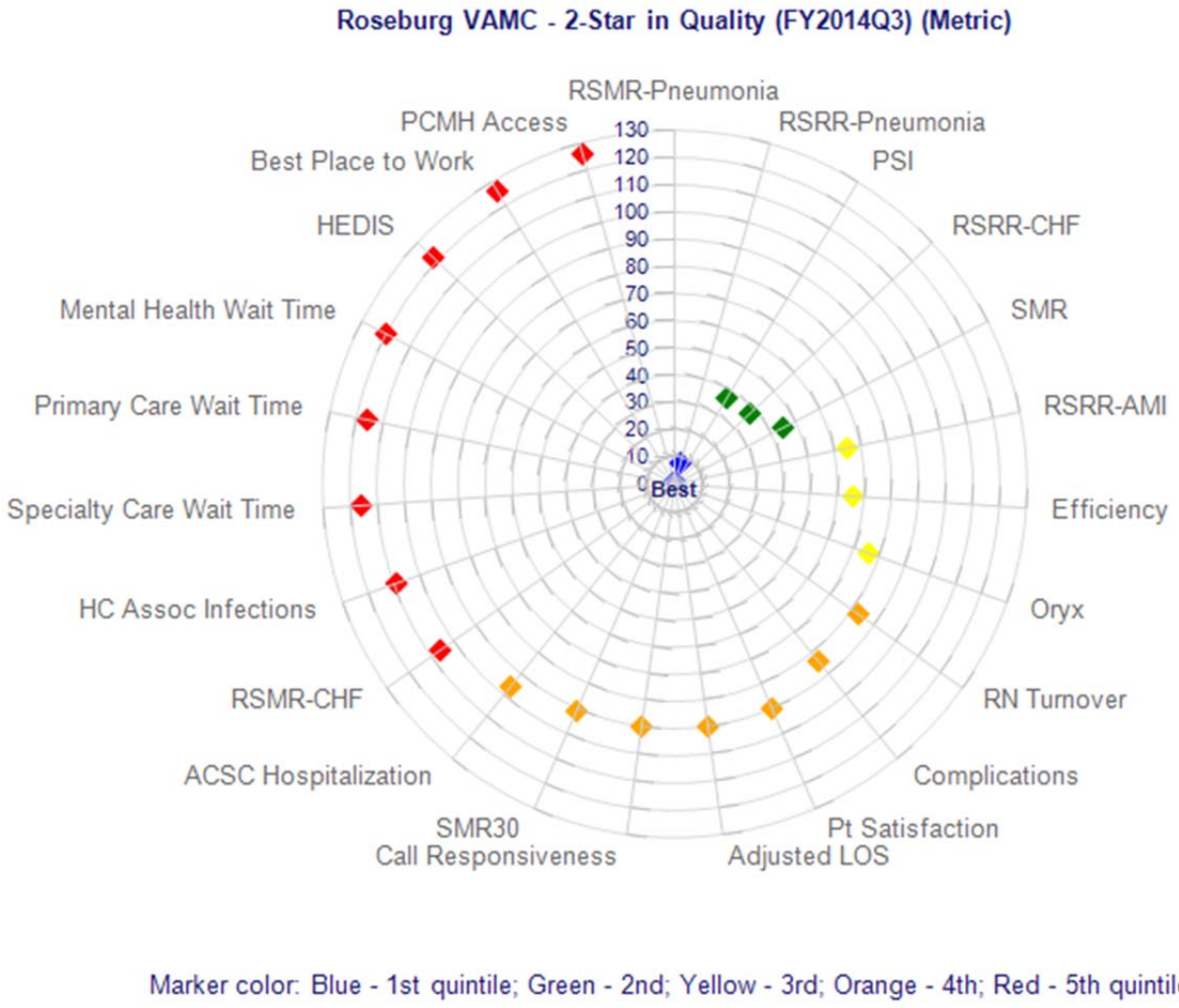
38. We recommended that facility managers ensure responsible clinicians either develop follow-up plans or document that no follow-up is indicated within the required timeframe.

39. We recommended that facility managers ensure patient notification of diagnostic test results within the required timeframe and that clinicians document notification.

Facility Profile (Roseburg/653) FY 2015 through November 2014[1]	
Type of Organization	Secondary
Complexity Level	3-Low complexity
Affiliated/Non-Affiliated	Affiliated
Total Medical Care Budget in Millions	$151.2
Number of:	
• **Unique Patients**	13,869
• **Outpatient Visits**	36,357
• **Unique Employees**[2]	726
Type and Number of Operating Beds (as of October 2014):	
• **Hospital**	37
• **CLC**	45
• **MH**	30
Average Daily Census (as of October 2014):	
• **Hospital**	18
• **CLC**	40
• **MH**	11
Number of Community Based Outpatient Clinics	3
Location(s)/Station Number(s)	Eugene/653BY North Bend/653GA Brookings/653GB
Veterans Integrated Service Network Number	20

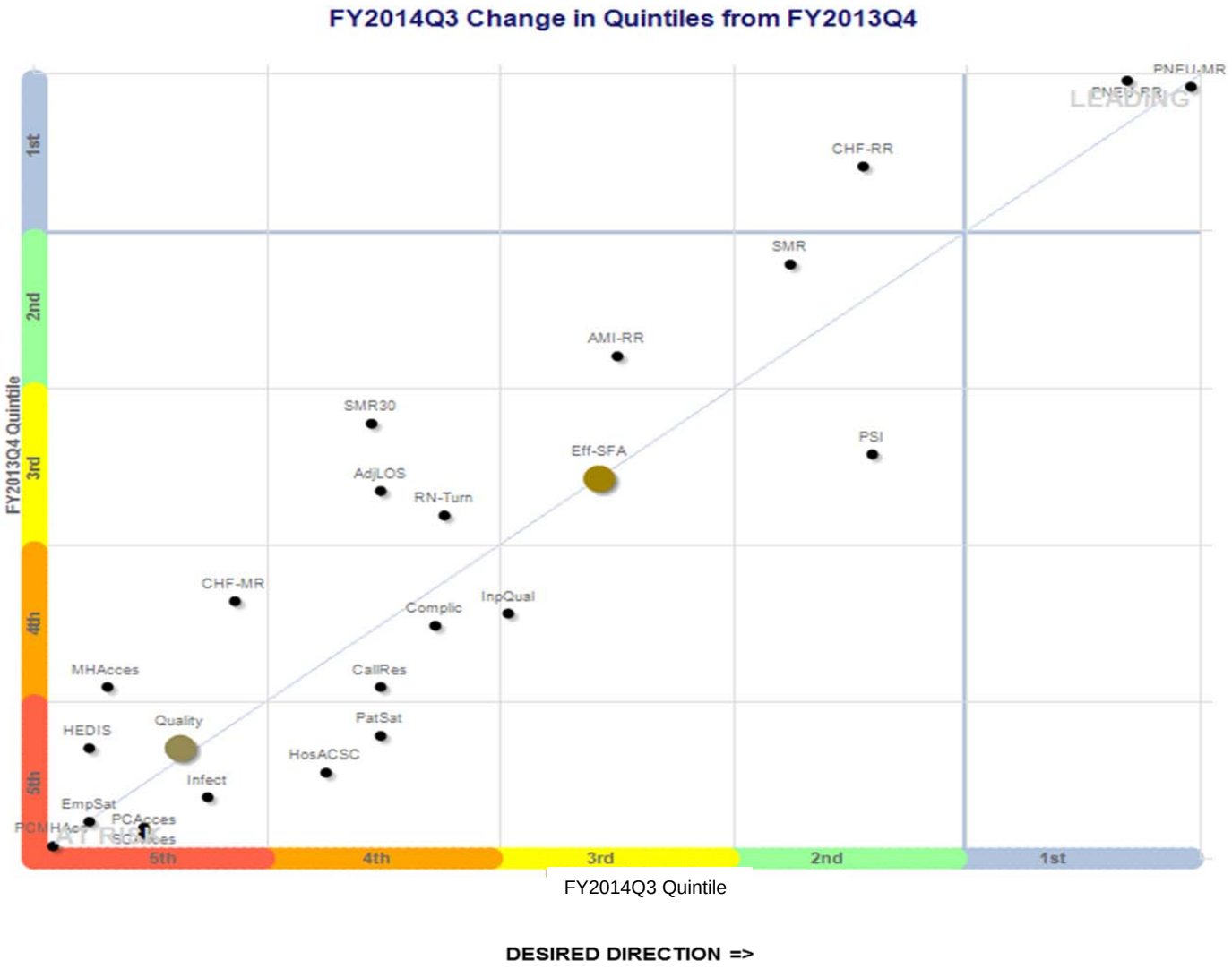
[1] All data is for FY 2015 through November 2014 except where noted.
[2] Unique employees involved in direct medical care (cost center 8200).

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

Veterans Integrated Service Network Director Comments

Department of Veterans Affairs

Memorandum

Date: February 4, 2015

From: Director, Northwest Network (10N20)

Subject: **CAP Review of the VA Roseburg Healthcare System, Roseburg, OR**

To: Director, Seattle Office of Healthcare Inspections (54SE)

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

1. Thank you for the opportunity to provide a status report on follow-up to the findings from the Combined Assessment Program Review of the VA Roseburg Healthcare System, Roseburg, OR.

2. Attached please find the facility concurrence and response to the findings from the review.

3. If you have additional questions or need further information, please contact Susan Green, Survey Coordinator, VISN 20 at (360) 567-4678.

Lawrence H. Carroll

Interim Facility Director Comments

Department of Veterans Affairs

Memorandum

Date: January 30, 2015

From: Interim Director, VA Roseburg Healthcare System, Roseburg, OR (653/00)

Subject: **CAP Review of the VA Roseburg Healthcare System, Roseburg, OR**

To: Director, Northwest Network (10N20)

1. On behalf of the VA Roseburg Healthcare System, Roseburg, Oregon, I would like to express my appreciation to the Office of the Inspector General (OIG) Survey Team for their comprehensive Combined Assessment Program (CAP) review conducted November 17 through 21, 2014.

2. We have reviewed the findings from the report. The facility responses addressing each recommendation are attached. The responses include actions that are in progress and those that have already been completed.

3. Please feel free to contact us if you have any concerns or questions regarding the responses.

Douglas V. Paxton, Sr., MSW
Interim Director, VA Roseburg Healthcare System

Comments to OIG's Report

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

OIG Recommendations

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

Concur

Target date for completion: June 30, 2015

Facility response: Privileging forms will be reviewed annually by the facility managers at the Executive Committee of the Medical Staff (ECMS) Credentialing and Privileging Committee. The annual review of privileging forms will be documented in the ECMS Credentialing and Privileging committee minutes.

Recommendation 2. We recommended that facility managers ensure that privileges granted are appropriate for the practitioners' skills and training.

Concur

Target date for completion: June 30, 2015

Facility response: The privileges granted to individual practitioners' will be aligned and appropriate to correspond with the individual practitioners' skills and training. The Executive Committee of the Medical Staff (ECMS) Credentialing and Privileging Committee will monitor for appropriate granting of privileges and document in the ECMS Credentialing and Privileging committee minutes.

Recommendation 3. We recommended that when conversions from observation bed status to acute admissions are 25–30 percent or more, the facility reassess observation criteria and utilization.

Concur

Target date for completion: June 30, 2015

Facility response: Hospitalists were educated on criteria for observation status. Utilization Review nurses review charts of observation admissions to ensure observation criteria are met. The Utilization Management Committee will report monthly data to the Acute Care Advisory Board (ACAB) on a quarterly basis. The Utilization Management Committee will track, trend, and analyze data regarding the appropriateness of observation status, and document action plans as appropriate. The Utilization Management Committee will provide reports to ACAB, which will provide

reports to the Executive Council of the Medical Staff (ECMS) on a quarterly basis. ECMS reports to the Quality Review Council on a quarterly basis. In addition, Quality Management maintains a spreadsheet to track ongoing compliance, and provides updates to the Quality Review Council at each meeting.

Recommendation 4. We recommended that the Acute Care Advisory Board review each code episode and that code reviews include screening for clinical issues prior to the code that may have contributed to the occurrence of the code.

Concur

Target date for completion: June 30, 2015

Facility response: A Subcommittee of the Acute Care Advisory Board (ACAB) was created to review each code episode and to ensure that code reviews include screening for clinical issues prior to the code that may have contributed to the occurrence of the code. This subcommittee will report monthly code data to ACAB. ACAB will review, analyze for improvement opportunities, and document analysis and action plans in the ACAB minutes. ACAB will provide reports to the Executive Council of the Medical Staff (ECMS) on a quarterly basis. ECMS reports to the Quality Review Council on a quarterly basis. In addition, Quality Management maintains a spreadsheet to track ongoing compliance, and provides updates to the Quality Review Council at each meeting.

Recommendation 5. We recommended that the facility keep the recipient list for the automated e-mail notification current.

Concur

Target date for completion: March 31, 2015

Facility response: The Veteran Administration Surgical Quality Improvement Program (VASQIP) Coordinator has updated the email recipient list on the VASQIP website for new incumbents, acting, or temporary positions for the Director, Chief of Staff, Chief of Surgery, Operating Room Nurse Manager, Surgical Quality Nurse, and Patient Safety Manager positions. The email recipient list will be reviewed quarterly and reported to Quality Review Council to assure ongoing accuracy.

Recommendation 6. We recommended that the facility analyze electronic health record data at least quarterly and include most services in the review of electronic health record quality.

Concur

Target date for completion: June 30, 2015

Facility response: The Medical Records Committee (MRC) will review the quality of entries in the electronic health record, analyze data, and include most services in the

review the quality of electronic health record (EMR) quarterly. The new Health Information Management Services (HIMS) Chief will coordinate the review of the quality of the EMR. MRC will provide reports to the Executive Council of the Medical Staff (ECMS) on a quarterly basis. ECMS reports to the Quality Review Council on a quarterly basis. In addition, Quality Management maintains a spreadsheet to track ongoing compliance, and provides updates to the Quality Review Council at each meeting.

Recommendation 7. We recommended that the facility implement a process for the destruction of original documents.

Concur

Target date for completion: June 30, 2015

Facility response: The scanning policy was revised to include incorporating steps for destruction of original documents. The new Health Information Management Services (HIMS) Chief will complete monthly compliance audits until compliance is achieved, and then will complete quarterly audits to demonstrate ongoing compliance. The HIMS Chief will report the results of the audits to the Medical Records Committee (MRC). MRC will provide reports to the Executive Council of the Medical Staff (ECMS) on a quarterly basis.

Recommendation 8. We recommended that the Safe Patient Handling Committee report patient handling injury data quarterly.

Concur

Target date for completion: September 30, 2015

Facility response: The Safe Patient Handling Manager (SPHM) will report quarterly to Environment of Care Council, with a cc to the Chief Nurse Executive, to assure ongoing oversight and compliance.

Recommendation 9. We recommended that the facility revise the policy for safe use of automated dispensing machines to include employee training and minimum competency requirements for users and that facility managers monitor compliance.

Concur

Target date for completion: June 30, 2015

Facility response: The Chief of Pharmacy will update the Automated Dispensing Machine Medical Center Memorandum (MCM) with the requirement for initial training and ongoing minimum competency review and monitoring of compliance for users and submit the MCM to the Pharmacy, Therapeutics & Nutrition Committee for review and concurrence. PT&N will provide reports to the Executive Council of the Medical Staff (ECMS) on a quarterly basis. ECMS reports to the Quality Review Council on a

quarterly basis. In addition, Quality Management maintains a spreadsheet to track ongoing compliance, and provides updates to the Quality Review Council at each meeting.

Recommendation 10. We recommended that the facility designate Automated Data Processing Applications Coordinators to train employees and to manage, implement, and maintain the computerized consult package.

Concur

Target date for completion: June 30, 2015

Facility response: The facility hired Program Analysts/Clinical Application Coordinators who will train employees and manage, implement and maintain the computerized consult package. These new positions report up to the facility's Director of Education. The Director of Education will provide a quarterly update regarding training to the Consult Committee. The Consult Committee will provide reports to the Executive Council of the Medical Staff (ECMS) on a quarterly basis. ECMS reports to the Quality Review Council on a quarterly basis. In addition, Quality Management maintains a spreadsheet to track ongoing compliance, and provides updates to the Quality Review Council at each meeting.

Recommendation 11. We recommended that the facility conduct cardiac arrest, contrast reaction, and fire emergency drills in magnetic resonance imaging and that facility managers monitor compliance.

Concur

Target date for completion: June 30, 2015

Facility response: The Magnetic Resonance Imaging (MRI) Safety Committee will ensure that cardiac arrest, contrast reaction, and fire emergency drills are conducted for the MRI Suite. The MRI Safety Committee will document the outcomes of these drills and any necessary action plans related to the planned drills to demonstrate ongoing compliance. MRI Safety Committee will provide reports to the Executive Council of the Medical Staff (ECMS) on a quarterly basis. ECMS reports to the Quality Review Council on a quarterly basis. In addition, Quality Management maintains a spreadsheet to track ongoing compliance, and provides updates to the Quality Review Council at each meeting.

Recommendation 12. We recommended that Level 2 magnetic resonance imaging personnel and/or radiologists document resolution in patients' electronic health records of all identified magnetic resonance imaging contraindications prior to the scan and that facility managers monitor compliance.

Concur

Target date for completion: June 30, 2015

Facility response: The Magnetic Resonance Imaging (MRI) Safety Committee developed a standard process to ensure documentation of resolution of patients' electronic health records of all identified magnetic resonance imaging contraindications. This standard process of documenting resolution will be completed by the Level 2 magnetic resonance imaging personnel and/or radiologists. The MRI Safety Committee will review monthly data, to assure compliance. Once compliance is reached, quarterly reviews will insure ongoing compliance. MRI Safety Committee will provide reports to the Executive Council of the Medical Staff (ECMS) on a quarterly basis. ECMS reports to the Quality Review Council on a quarterly basis. In addition, Quality Management maintains a spreadsheet to track ongoing compliance, and provides updates to the Quality Review Council at each meeting.

Recommendation 13. We recommended that the facility ensure all designated Level 1 ancillary staff and Level 2 magnetic resonance imaging personnel receive annual level-specific magnetic resonance imaging safety training and that facility managers monitor compliance.

Concur

Target date for completion: June 30, 2015

Facility response: The Magnetic Resonance Imaging (MRI) Safety Committee will ensure all designated Level 1 ancillary staff and Level 2 MRI personnel receive annual level-specific MRI safety training. The MRI Safety Committee will monitor staff level-specific MRI safety training to ensure compliance. MRI Safety Committee will provide reports to the Executive Council of the Medical Staff (ECMS) on a quarterly basis. ECMS reports to the Quality Review Council on a quarterly basis. In addition, Quality Management maintains a spreadsheet to track ongoing compliance, and provides updates to the Quality Review Council at each meeting.

Recommendation 14. We recommended that facility employees regularly test the two-way communication device and that facility managers monitor compliance.

Concur

Target date for completion: September 30, 2015

Facility response: Testing and documentation was implemented on the two-way communication device for the Magnetic Resonance Imaging suite. The MRI Safety Committee will receive a quarterly monitor of the testing and documentation of the two-way communication device to ensure compliance. MRI Safety Committee will provide reports to the Executive Council of the Medical Staff (ECMS) on a quarterly basis. ECMS reports to the Quality Review Council on a quarterly basis. In addition, Quality Management maintains a spreadsheet to track ongoing compliance, and provides updates to the Quality Review Council at each meeting.

Recommendation 15. We recommended that the facility update local magnetic resonance imaging policies for policy changes and review the policies at least every 3 years and that facility managers monitor compliance.

Concur

Target date for completion: June 30, 2015

Facility response: The Imaging Manager will update the Medical Center Memorandum (MCM) and Standard Operating Procedures (SOPs) related to Magnetic Resonance Imaging (MRI) processes to ensure compliance with national directives/handbooks. The MRI Safety Committee will track and monitor this review in a report to the MRI Safety Committee to ensure compliance. MRI Safety Committee will provide reports to the Executive Council of the Medical Staff (ECMS) on a quarterly basis. ECMS reports to the Quality Review Council on a quarterly basis. In addition, Quality Management maintains a spreadsheet to track ongoing compliance, and provides updates to the Quality Review Council at each meeting.

Recommendation 16. We recommended that the facility revise the stroke policy to include clinical protocols or pathways, timeliness of completion and interpretation of computed tomography scans, emergent transfer to the nearest primary stroke center, the difference in approach to patients presenting within the facility's defined timeframe for tissue plasminogen activator and those presenting outside of that timeframe, and screening for difficulty swallowing prior to oral intake and that facility managers fully implement the revised policy.

Concur

Target date for completion: June 30, 2015

Facility response: The Medical Director for the Emergency Department and the Medical Director for Specialty Care services will revise the stroke policy to include clinical protocols or pathways, timeliness of completion and interpretation of computed tomography scans, emergent transfer to the nearest primary stroke center, the difference in approach to patients presenting within the facility's defined timeframe for tissue plasminogen activator and those presenting outside of that timeframe, and screening for difficulty swallowing prior to oral intake. The Acute Care Advisory Board will monitor and track to assure sustained compliance with the revised policy on a quarterly basis. ACAB will provide reports to the Executive Council of the Medical Staff (ECMS) on a quarterly basis. ECMS reports to the Quality Review Council on a quarterly basis. In addition, Quality Management maintains a spreadsheet to track ongoing compliance, and provides updates to the Quality Review Council at each meeting.

Recommendation 17. 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: June 30, 2015

Facility response: Emergency Room Department Nursing personnel were educated on National Institutes of Health (NIH) stroke scales. A template note to document (NIH) stroke scales was developed. Monthly medical record documentation reviews are completed to evaluate compliance with (NIH) stroke scales documentation requirements. Once compliance is achieved, quarterly reports will be provided to the Acute Care Advisory Board (ACAB). ACAB will provide reports to the Executive Council of the Medical Staff (ECMS) on a quarterly basis. ECMS reports to the Quality Review Council on a quarterly basis. In addition, Quality Management maintains a spreadsheet to track ongoing compliance, and provides updates to the Quality Review Council at each meeting.

Recommendation 18. We recommended that facility managers post stroke guidelines in the Emergency Department and community living center and on all inpatient units.

Concur

Target date for completion: June 30, 2015

Facility response: The Medical Director for the Emergency Department ensured that the VHA Acute Ischemic Stroke Algorithm was posted in clinical areas. An annual review will be completed and reported to the Acute Care Advisory Board to ensure ongoing compliance. ACAB will provide reports to the Executive Council of the Medical Staff (ECMS) on a quarterly basis. ECMS reports to the Quality Review Council on a quarterly basis. In addition, Quality Management maintains a spreadsheet to track ongoing compliance, and provides updates to the Quality Review Council at each meeting.

Recommendation 19. We recommended that clinicians screen patients for difficulty swallowing prior to oral intake and that facility managers monitor compliance.

Concur

Target date for completion: June 30, 2015

Facility response: A dysphagia screening template was developed, and Emergency Department Nursing personnel were educated on dysphagia screening. Monthly medical record documentation reviews to evaluate ongoing compliance with dysphagia screening documentation will be provided to the Acute Care Advisory Board to ensure compliance. Once compliance is achieved, quarterly reports will ensure ongoing compliance. ACAB will provide reports to the Executive Council of the Medical Staff

(ECMS) on a quarterly basis. ECMS reports to the Quality Review Council on a quarterly basis. In addition, Quality Management maintains a spreadsheet to track ongoing compliance, and provides updates to the Quality Review Council at each meeting.

Recommendation 20. We recommended that clinicians provide printed stroke education to patients upon discharge and that facility managers monitor compliance.

Concur

Target date for completion: June 30, 2015

Facility response: The Medical Director of the Emergency Department provided clinicians with printed stroke education to be provided to patients upon discharge. Monthly medical record reviews will be completed to evaluate for compliance in documenting that printed stroke education was provided to patients upon discharge. Once compliance is achieved, reports will be provided to the Acute Care Advisory Board on a quarterly basis. ACAB will provide reports to the Executive Council of the Medical Staff (ECMS) on a quarterly basis. ECMS reports to the Quality Review Council on a quarterly basis. In addition, Quality Management maintains a spreadsheet to track ongoing compliance, and provides updates to the Quality Review Council at each meeting.

Recommendation 21. We recommended that facility managers provide a stroke education program for employees who assess and treat stroke patients.

Concur

Target date for completion: June 30, 2015

Facility response: Emergency Department nursing personnel completed the required stroke education program (VA 18919 Acute Stroke). All newly assigned Emergency Department nursing personnel will be required to complete the required stroke education program (VA 18919 Acute Stroke). The education program will also be assigned to providers and dietitians who are likely to care for acute stroke patients. Compliance of the required stroke education program (VA 18919 Acute Stroke) training will be monitored annually by the Acute Care Advisory Board. ACAB will provide reports to the Executive Council of the Medical Staff (ECMS) on a quarterly basis. ECMS reports to the Quality Review Council on a quarterly basis. In addition, Quality Management maintains a spreadsheet to track ongoing compliance, and provides updates to the Quality Review Council at each meeting.

Recommendation 22. We recommended that domiciliary employees conduct and document monthly domiciliary self-inspections that include all required elements, submit

work orders for items needing repair, and ensure correction of any identified deficiencies and that domiciliary managers monitor compliance.

Concur

Target date for completion: June 30, 2015

Facility response: The Program Director for MH-RRTP developed a safety, security, and privacy self-inspection tool and scheduled a recurrent appointment to complete self-inspection on the 1st Monday of each month. The first safety self-inspection was completed 12/1/2014. The second self-inspection was completed 1/5/15; next self-inspection scheduled for 2/2/15. The Program Director will review the self-inspections monthly and report on completion of monthly self-inspections and the submission of work orders, as needed, to the Mental Health Executive Committee (MHEC) on a quarterly basis. MHEC will provide reports to the Executive Council of the Medical Staff (ECMS) on a quarterly basis. ECMS reports to the Quality Review Council on a quarterly basis. In addition, Quality Management maintains a spreadsheet to track ongoing compliance, and provides updates to the Quality Review Council at each meeting.

Recommendation 23. We recommended that domiciliary employees perform and document contraband inspections, rounds of all public spaces, and inspections for unsecured medications and that domiciliary managers monitor compliance.

Concur

Target date for completion: June 30, 2015

Facility response: The Program Director for MH-RRTP assigned daily contraband inspections to two RRTP staff. Rounds are a routine part of RRTP 24/7 staff shift and are to be documented each time performed. They were initiated 12/1/14; the most recent self-inspection was completed 1/27/14. The Program Director reviews documentation on a weekly basis, and will report the weekly data to the Mental Health Executive Committee (MHEC) on a quarterly basis to assure continued compliance. MHEC will provide reports to the Executive Council of the Medical Staff (ECMS) on a quarterly basis. ECMS reports to the Quality Review Council on a quarterly basis. In addition, Quality Management maintains a spreadsheet to track ongoing compliance, and provides updates to the Quality Review Council at each meeting.

Recommendation 24. We recommend that the domiciliary managers ensure that written agreements are in place acknowledging resident responsibility for medication security.

Concur

Target date for completion: June 30, 2015

Facility response: The MH-RRTP nurse was instructed to reinstate written agreements acknowledging resident responsibility for medication security with residents upon admission. RRTP manager will review on a monthly basis, and will report to the Mental Health Executive Committee (MHEC) on a quarterly basis to assure continued compliance. MHEC will provide reports to the Executive Council of the Medical Staff (ECMS) on a quarterly basis. ECMS reports to the Quality Review Council on a quarterly basis. In addition, Quality Management maintains a spreadsheet to track ongoing compliance, and provides updates to the Quality Review Council at each meeting.

Recommendation 25. We recommended that facility managers ensure that closed circuit television with recording capabilities is installed in all domiciliary public areas.

Concur

Target date for completion: February 28, 2015

Facility response: The Program Director for MH-RRTP submitted a work order for the CCTV to be installed in the hallway. Information Technology and Facilities Management Services are collaborating to assure it is installed and functioning.

Recommendation 26. We recommended that the facility revise the emergency airway management policy to include a plan for managing a difficult airway.

Concur

Target date for completion: April 30, 2015

Facility response: The Director of Surgery and the Medical Director of the Emergency Department collaborated to finalize the revision of the emergency airway management policy to include a plan for managing a difficult airway. The draft policy has been reviewed by the Executive Council of the Medical Staff.

Recommendation 27. 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: June 30, 2015

Facility response: The emergency airway management (EAM) policy was revised to provide a three month time-frame for initial clinicians to complete the mandatory training elements required in by directive for EAM. The emergency airway management competency assessment will be monitored by the Medical Director of the Emergency Department on a monthly basis and reported to the Acute Care Advisory Board (ACAB) on a quarterly basis. ACAB will provide reports to the Executive Council of the Medical Staff (ECMS) on a quarterly basis. ECMS reports to the Quality Review Council on a

quarterly basis. In addition, Quality Management maintains a spreadsheet to track ongoing compliance, and provides updates to the Quality Review Council at each meeting.

Recommendation 28. We recommended that the facility ensure clinician reassessment for continued emergency airway management competency includes reviews of clinician-specific emergency airway management data and that facility managers monitor compliance.

Concur

Target date for completion: June 30, 2015

Facility response: At time of re-credentialing, all required clinicians with emergency airway management (EAM) competency will have their specific EAM data reviewed, and will have completed the requirements for continued EAM competency as per the revised policy for EAM. The emergency airway management competency assessment will be monitored quarterly by the Medical Director of the Emergency Department, the Acute Care Advisory Board, and the Executive Board of the Medical Staff for Credentialing and Privileging. The first report will be provided NLT 6/30/15.

Recommendation 29. We recommended that the facility ensure clinician reassessment for continued emergency airway management competency includes all required elements and that facility managers monitor compliance.

Concur

Target date for completion: June 30, 2015

Facility response: The Acute Care Advisory Board will monitor for clinician reassessment of continued emergency airway management competency with all of the required elements. A quarterly report will be submitted to the Acute Care Advisory Board to monitor for sustained compliance, with the first report NLT 6/30/15. ACAB will provide reports to the Executive Council of the Medical Staff (ECMS) on a quarterly basis. ECMS reports to the Quality Review Council on a quarterly basis. In addition, Quality Management maintains a spreadsheet to track ongoing compliance, and provides updates to the Quality Review Council at each meeting.

Recommendation 30. We recommended that the facility ensure that clinicians reassessed for continued emergency airway management scope of practice have a statement related to emergency airway management included in the scope of practice.

Concur

Target date for completion: June 30, 2015

Facility response: The Acute Care Advisory Board will monitor for clinician statements related to EAM scope of practice. A quarterly report will be submitted by the

Credentialing and Privileging Coordinator and the Respiratory Therapist Manager to the Acute Care Advisory Board to demonstrate sustained compliance, with the first report NLT 6/30/15. ACAB will provide reports to the Executive Council of the Medical Staff (ECMS) on a quarterly basis. ECMS reports to the Quality Review Council on a quarterly basis. In addition, Quality Management maintains a spreadsheet to track ongoing compliance, and provides updates to the Quality Review Council at each meeting.

Recommendation 31. We recommended that the facility ensure a clinician with emergency airway management privileges or scope of practice is available during all hours the facility provides patient care and that facility managers monitor compliance.

Concur

Target date for completion: June 30, 2015

Facility response: There is a hospitalist or Emergency Department provider on duty 24/7. All of these providers will have the appropriate documentation of privileges and competencies on file NLT April 30, 2015. Acute Care Advisory Board (ACAB) will monitor to assure continued compliance, and will report to the Executive Council of the Medical Staff. ECMS reports to the Quality Review Council on a quarterly basis. In addition, Quality Management maintains a spreadsheet to track ongoing compliance, and provides updates to the Quality Review Council at each meeting.

Recommendation 32. We recommended that the facility ensure that all Emergency Department clinicians and clinicians with moderate sedation privileges have emergency airway management privileges.

Concur

Target date for completion: June 30, 2015

Facility response: All of the Emergency Department Clinicians, Respiratory Therapists, and Hospitalists will be required to have EAM competency. The emergency airway management competency assessment will be monitored quarterly by the Medical Director of the Emergency Department, the Acute Care Advisory Board, and the Executive Board of the Medical Staff for Credentialing and Privileging.

Recommendation 33. We recommended that facility managers strengthen processes to minimize a repeat occurrence in which non-privileged providers perform intubations and in instances of occurrence, initiate root cause analyses.

Concur

Target date for completion: June 30, 2015

Facility response: The emergency airway management monitoring for occurrences of non-privileged providers performing intubations will be monitored daily by the Medical

Director of the Emergency Department, and reported to the Patient Safety Manager (patient incident report) and the Risk Manager for Peer Review. The Acute Care Advisory Board and the Executive Board of the Medical Staff for Credentialing and Privileging will receive quarterly reports.

Recommendation 34. We recommended that facility managers ensure quarterly reporting of emergency airway management data to the designated committee.

Concur

Target date for completion: September 30, 2015

Facility response: The emergency airway management data will be reported, monitored, analyzed, and documented quarterly by the Acute Care Advisory Board. ACAB will provide reports to the Executive Council of the Medical Staff (ECMS) on a quarterly basis. ECMS reports to the Quality Review Council on a quarterly basis. In addition, Quality Management maintains a spreadsheet to track ongoing compliance, and provides updates to the Quality Review Council at each meeting.

Recommendation 35. We recommended that facility managers ensure reporting of results of completed Focused Professional Practice Evaluations for all newly hired licensed independent practitioners to the Medical Executive Committee.

Concur

Target date for completion: June 30, 2015

Facility response: The Credentialing and Privileging Coordinator will track completion of FPPEs and report monthly data to the Executive Council of the Medical Staff to assure compliance. Once compliance is achieved, quarterly reporting will ensure ongoing compliance.

Recommendation 36. We recommended that facility managers ensure the Medical Records Committee monitors the copy and paste functions.

Concur

Target date for completion: September 30, 2015

Facility response: The new Health Information Management Services (HIMS) Chief will coordinate monthly audits of the copy and paste functions of electronic health record (EMR) and submit reports to the Medical Records Committee (MRC) until compliance is reached. After that quarterly audits will ensure ongoing compliance. MRC will provide reports to the Executive Council of the Medical Staff (ECMS) on a quarterly basis. ECMS reports to the Quality Review Council on a quarterly basis. In addition, Quality Management maintains a spreadsheet to track ongoing compliance, and provides updates to the Quality Review Council at each meeting.

Recommendation 37. We recommended that facility managers ensure patient notification of positive colorectal cancer screening test results within the required timeframe and that clinicians document notification.

Concur

Target date for completion: June 30, 2015

Facility response: Results of monthly audits related to documentation of patient notification of positive results will be provided to the PACT Leadership Team. Individualized, specific 1:1 education will be provided to provider(s) as needed. Audits that identify negative patient outcomes are reported the Risk Manager for Peer Review. The audits of the colorectal cancer screening test are submitted monthly to Quality Review Council for compliance oversight. Once compliance is achieved, quarterly reporting will ensure ongoing compliance.

Recommendation 38. We recommended that facility managers ensure responsible clinicians either develop follow-up plans or document that no follow-up is indicated within the required timeframe.

Concur

Target date for completion: June 30, 2015

Facility response: Colorectal cancer screening tests are audited for documentation of follow-up plans or documentation that no follow-up is indicated within the required timeframe and results are provided to the PACT Leadership Team for follow-up with the involved providers as indicated. These audits are submitted monthly to Quality Review Council for compliance oversight. Once compliance is achieved, quarterly reporting will ensure ongoing compliance.

Recommendation 39. We recommended that facility managers ensure patient notification of diagnostic test results within the required timeframe and that clinicians document notification.

Concur

Target date for completion: June 30, 2015

Facility response: Monthly audits of documentation of diagnostic test results notification to patients within required timeframes are provided to the PACT Leadership Team for follow-up with the involved providers. The results of the audits are submitted monthly to Quality Review Council for compliance oversight. Once compliance is achieved, quarterly reporting will ensure ongoing compliance.

Office of Inspector General
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Endnotes

[a] References used for this topic included:
- VHA Directive 1026, *VHA Enterprise Framework for Quality, Safety, and Value*, August 2, 2013.
- VHA Handbook 1050.01, *VHA National Patient Safety Improvement Handbook*, March 4, 2011.
- VHA Directive 2010-025, *Peer Review for Quality Management*, June 3, 2010.
- VHA Directive 2010-032, *Safe Patient Handling Program and Facility Design*, June 28, 2010.
- VHA Directive 1036, *Standards for Observation in VA Medical Facilities*, February 6, 2014.
- VHA Handbook 1100.19, *Credentialing and Privileging*, October 15, 2012.
- VHA Handbook 1102.01, *National Surgery Office*, January 30, 2013.
- VHA Directive 2008-063, *Oversight and Monitoring of Cardiopulmonary Resuscitative Events and Facility Cardiopulmonary Resuscitation Committees*, October 17, 2008.
- VHA Handbook 1907.01, *Health Information Management and Health Records*, July 22, 2014.

[b] References used for this topic included:
- VHA Directive 2010-052, *Management of Wandering and Missing Patients*, December 3, 2010.
- VHA Directive 2011-007, *Required Hand Hygiene Practices*, February 16, 2011.
- Under Secretary for Health, "Non- Research Animals in Health Care Facilities," Information Letter 10-2009-007, June 11, 2009.
- Various requirements of The Joint Commission, the Occupational Safety and Health Administration, the International Association of Healthcare Central Service Materiel Management, the National Fire Protection Association, the Health Insurance Portability and Accountability Act, Underwriters Laboratories, 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 were:
- VHA Handbook 1162.02, *Mental Health Residential Rehabilitation Treatment Program (MH RRTP)*, December 22, 2010.
- VHA Handbook 1330.01, *Health Care Services for Women Veterans*, May 21, 2010.
- Requirements of the VHA Center for Engineering and Occupational Safety and Health and the National Fire Protection Association.

[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.

[i] The references used for this topic were:
- VHA Handbook 1100.19.
- VHA Handbook 1907.01.

[j] The references used for this topic were:
- VHA Directive 2007-004, *Colorectal Cancer Screening*, January 12, 2007 (corrected copy).
- VHA Directive 2009-019, *Ordering and Reporting Test Results*, March 24, 2009.