Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 15-00069-199

Combined Assessment Program Review of the VA Puget Sound Health Care System Seattle, Washington

April 9, 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
EAM	emergency airway management
EHR	electronic health record
EOC	environment of care
facility	VA Puget Sound Health Care System
FY	fiscal year
MH	mental health
MRI	magnetic resonance imaging
NA	not applicable
NM	not met
OIG	Office of Inspector General
PTSD	post-traumatic stress disorder
QM	quality management
SICU	surgical intensive care unit
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

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Executive Summary

Review Purpose: The purpose of the review was to evaluate selected health care facility operations, focusing on patient care quality and the environment of care, and to provide crime awareness briefings. We conducted the review the week of January 26, 2015.

Review Results: The review covered eight activities. We made no recommendations in the following activity:

- Surgical Complexity

The facility's reported accomplishment was integration of chaplaincy spiritual principles in the treatment of mental health conditions.

Recommendations: We made recommendations in the following seven activities:

Quality Management: Ensure the Peer Review Committee consistently invites involved providers to submit comments to and/or appear before the committee prior to the final level assignment. Reassess observation criteria and utilization when conversions from observation bed status to acute admissions are 25–30 percent or more. Include the Chief of Staff as a member of the Surgical Work Group. Ensure the Safe Patient Handling Committee tracks patient handling injury data. Require a third party to conduct quality assurance reviews on a sample of scanned documents.

Environment of Care: Require that Environment of Care Board and Safety Committee minutes include corrective actions to address identified deficiencies and track those actions to closure. Ensure patient care areas, public restrooms, and community living center treatment carts containing resident care supplies are clean. Require that critical medical equipment in the community living center is plugged into outlets that function in the event of a power loss.

Medication Management: Check emergency crash carts with the frequency required by local policy. Revise the policy for safe use of automated dispensing machines to include oversight of overrides and minimum competency requirements for users. Ensure designated employees receive automated dispensing machine training and competency assessment. Require nursing reviewers to sign the monthly medication review forms.

Coordination of Care: Ensure the recently chartered Consult Management Committee meets regularly and documents oversight of consult management. Require that requestors consistently select the proper consult title and that consultants do not change the consult request status for inappropriate reasons.

Magnetic Resonance Imaging Safety: Complete secondary patient safety screenings immediately prior to imaging. Ensure Level 2 magnetic resonance imaging personnel

review and sign secondary patient safety screenings forms prior to imaging. Require that radiologists and/or Level 2 magnetic resonance imaging personnel document resolution of all identified contraindications prior to the scan.

Acute Ischemic Stroke Care: Complete and document National Institutes of Health stroke scales for each stroke patient. Screen patients for difficulty swallowing prior to oral intake.

Emergency Airway Management: Include all required elements in clinician reassessment for continued emergency airway management competency. Ensure the American Lake division follows local emergency airway management policy, or if the facility plans to perform intubations in areas designated to call 911, update the local emergency airway management policy, and ensure privileged providers or clinicians with emergency airway management scope of practice are available. Report emergency airway management data to the designated committee with the frequency required by local policy.

Comments

The Veterans Integrated Service Network and Facility Directors agreed with the Combined Assessment Program review findings and recommendations and provided acceptable improvement plans. (See Appendixes C and D, pages 27–38, for the full text of the Directors' comments.) We 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 eight activities:

- QM
- EOC
- Medication Management
- Coordination of Care
- MRI Safety
- Acute Ischemic Stroke Care
- Surgical Complexity
- EAM

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

The review covered facility operations for FY 2013, FY 2014, and FY 2015 through January 30, 2015, 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 Puget Sound Health Care System, Seattle, Washington,* Report No. 11-04569-141, April 3, 2012).

During this review, we presented crime awareness briefings for 156 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 685 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

Bridging Chaplaincy and MH

The facility has integrated chaplaincy spiritual principles in the treatment of MH conditions. Accelerated growth has occurred since 2012 as veterans process the meaning of forgiveness, self-identity, and faith and the power of a redemptive community.

The Chaplain Service operates alongside psychology and social workers in the Addiction Treatment Center, the Women's Trauma and Recovery Center, the PTSD outpatient clinic, and primary MH. For example, the domiciliary offers a weekly "Integrated Life" group on Sunday afternoons, which a chaplain and a social worker co-facilitate, and chaplains are facilitating a weekly MH grief and loss group. The Addiction Treatment Center and MH social workers refer clients to these groups. A chaplain co-facilitates 12-week sessions of a PTSD cognitive processing therapy group with two PTSD clinic staff and attends the weekly PTSD staff meeting. In addition, chaplains are co-located in the MH Patient Aligned Care Teams to address the MH needs of veterans from a spiritual or moral point of view rather than just clinical to treat the whole veteran and not just the condition or clinical symptoms.

As a result of the integration between chaplaincy and MH, many veterans report significant gains in their post-traumatic growth and healing and improvements in their ability to cope with distractions.

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, 15 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.		
X	Peer reviewed deaths met selected requirements: • Peers completed reviews within specified timeframes. • The Peer Review Committee reviewed cases receiving initial Level 2 or 3 ratings. • Involved providers were invited to provide input prior to the final Peer Review Committee determination.	For the 12-month period May 1, 2013, through April 30, 2014: • For several death cases that received initial Level 2 or 3 ratings, the Peer Review Committee did not invite involved providers to provide input prior to the final determination.	**1.** We recommended that when cases receive initial Level 2 or 3 ratings, the Peer Review Committee consistently invite involved providers to submit comments to and/or appear before the committee prior to the final level assignment.

NM	Areas Reviewed (continued)	Findings	Recommendations
	Credentialing and privileging processes met selected requirements: • Facility managers reviewed privilege forms annually and ensured proper approval of revised forms. • Facility managers ensured appropriate privileges for licensed independent practitioners. • Facility managers removed licensed independent practitioners' access to patients' EHRs upon separation. • Facility managers properly maintained licensed independent practitioners' folders.		
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.	Twelve months of data reviewed: • For March through May 2014, the facility converted 32 percent of observation patients to acute admissions but did not reassess observation criteria or utilization during that time.	**2.** 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.
	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
X	The surgical review process met selected requirements: • An interdisciplinary committee with appropriate leadership and clinical membership met monthly to review surgical processes and outcomes. • The Surgical Work Group reviewed surgical deaths with identified problems or opportunities for improvement. • The Surgical Work Group reviewed additional data elements.	Six months of Surgical Work Group meeting minutes reviewed: • The Chief of Staff was not a member.	**3.** We recommended that the Surgical Work Group include the Chief of Staff as a member.
	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 track patient handling injury data.	**4.** We recommended that the Safe Patient Handling Committee track patient handling injury data.
	The process to review the quality of entries in the EHR met selected requirements: • A committee reviewed EHR quality. • A committee analyzed data at least quarterly. • Reviews included data from most services and program areas.		
X	The policy for scanning internal forms into EHRs included the following required items: • Quality of the source document and an alternative means of capturing data when the quality of the document is inadequate. • A correction process if scanned items have errors.	• A third party did not conduct quality assurance reviews on a sample of the scanned documents.	**5.** We recommended that the facility ensure a third party conducts quality assurance reviews on a sample of the scanned documents.

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

EOC

The purpose of this review was to determine whether the facility maintained a clean and safe health care environment in accordance with applicable requirements. We also determined whether the facility met selected requirements in critical care and the CLC.[b]

At the Seattle division, we inspected the CLC, critical care (medical intensive care unit and SICU), the Emergency Department, inpatient units (MH, medical/telemetry, and spinal cord injury), and primary care clinics. At the American Lake division, we inspected the CLC, primary care clinics, and the urgent care clinic. Additionally, we reviewed relevant documents, including inspection documentation for 10 alarm-equipped medical devices in critical care, and 40 employee training records (20 critical care and 20 CLC) and conversed with key employees and managers. The table below shows the areas reviewed for this topic. The areas marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

NM	Areas Reviewed for General EOC	Findings	Recommendations
X	EOC Committee minutes reflected sufficient detail regarding identified deficiencies, corrective actions taken, and tracking of corrective actions to closure for the facility and the community based outpatient clinics.	Six months of EOC Board and Safety Committee meeting minutes reviewed: • Minutes did not include corrective actions to address identified deficiencies.	**6.** We recommended that Environment of Care Board and Safety Committee minutes include corrective actions to address identified deficiencies and track those actions to closure.
	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.		

NM	Areas Reviewed for General EOC (continued)	Findings	Recommendations
X	The facility met environmental safety requirements.	• Six of seven patient care areas contained dirty floors and dusty horizontal surfaces. • Four of six public restrooms had dirty walls and floors.	**7.** We recommended that facility managers ensure patient care areas and public restrooms are clean and monitor compliance.
	The facility met infection prevention requirements.		
	The facility met medication safety and security requirements.		
	The facility met privacy requirements.		
	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.		
	Areas Reviewed for Critical Care		
	Designated critical care employees received bloodborne pathogens training during the past 12 months.		
	Alarm-equipped medical devices used in critical care were inspected/checked according to local policy and/or manufacturers' recommendations.		
	The facility met fire safety requirements in critical care.		
X	The facility met environmental safety requirements in critical care.	• Rooms on both critical care units had dusty horizontal surfaces and debris on the floors.	See recommendation 7.
	The facility met infection prevention requirements in critical care.		
	The facility met medication safety and security requirements in critical care.		
	The facility met medical equipment requirements in critical care.		

NM	Areas Reviewed for Critical Care (continued)	Findings	Recommendations
	The facility met privacy requirements in critical care.		
	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.		
	Areas Reviewed for CLC		
	Designated CLC employees received bloodborne pathogens training during the past 12 months.		
NA	For CLCs with resident animal programs, the facility conducted infection prevention risk assessments and had policies addressing selected requirements.		
NA	For CLCs with elopement prevention systems, the facility documented functionality checks at least every 24 hours and documented complete system checks annually.		
	The facility met fire safety requirements in the CLC.		
X	The facility met environmental safety requirements in the CLC.	• At the American Lake division, resident rooms prepared for new resident admissions had dusty horizontal surfaces. • Occupied resident rooms at both divisions had dirty floors and dusty horizontal surfaces. • At the American Lake division, three treatment carts with care supplies were dirty.	See recommendation 7. **8.** We recommended that facility managers ensure community living center treatment carts containing resident care supplies are clean and monitor compliance.
	The facility met infection prevention requirements in the CLC.		

NM	Areas Reviewed for CLC (continued)	Findings	Recommendations
	The facility met medication safety and security requirements in the CLC.		
X	The facility met medical equipment requirements in the CLC.	• At the Seattle division, three critical medical equipment items in the CLC were not plugged into outlets that function during a power loss.	**9.** We recommended that facility managers ensure critical medical equipment in the community living center is plugged into outlets that function in the event of a power loss and monitor compliance.
	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 a CLC, the SICU, an inpatient medical unit, and the urgent care clinic and for these areas reviewed documentation of narcotic wastage from automated dispensing machines and inspected crash carts containing emergency medications. The table below shows the areas reviewed for this topic. The areas marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

NM	Areas Reviewed	Findings	Recommendations
	Facility policy addressed medication receipt in patient care areas, storage procedures until administration, and staff authorized to have access to medications and areas used to store them.		
	The facility required two signatures on controlled substances partial dose wasting.		
X	The facility defined those medications and supplies needed for emergencies and procedures for crash cart checks, checks included all required elements, and the facility conducted checks with the frequency required by local policy.	• Two emergency crash carts on the SICU did not consistently receive checks daily.	**10.** We recommended that facility managers ensure emergency crash carts receive checks with the frequency required by local policy and monitor compliance.
	The facility prohibited storage of potassium chloride vials in patient care areas.		
	If the facility stocked heparin in concentrations of more than 5,000 units per milliliter in patient care areas, the Chief of Pharmacy approved it.		

NM	Areas Reviewed (continued)	Findings	Recommendations
	The facility maintained a list of the look-alike and sound-alike medications it stores, dispenses, and administers; reviewed this list annually and ensured it was available for staff reference; and had labeling/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 oversight of overrides and minimum competency requirements for users. • Six nursing employees did not have documentation of training and competency assessment for automated dispensing machines.	**11.** We recommended that the facility revise the policy for safe use of automated dispensing machines to include oversight of overrides and minimum competency requirements for users and that facility managers monitor compliance. **12.** We recommended that facility managers ensure designated employees receive automated dispensing machine training and competency assessment and monitor compliance.
	The facility employed practices to prevent wrong-route drug errors.		
	Medications prepared but not immediately administered contained labels with all required elements.		

NM	Areas Reviewed (continued)	Findings	Recommendations
	The facility removed medications awaiting destruction or stored them separately from medications available for administration.		
	The facility met multi-dose insulin pen requirements.		
X	The facility complied with any additional elements required by VHA or local policy.	Facility policy on drug distribution and accountability reviewed, which required signatures by both the nursing and pharmacy reviewer on the designated monthly medication review form: • Review forms for the medical intensive care unit and the operating room did not contain signatures of the nursing reviewer.	**13.** We recommended that nursing reviewers sign the monthly medication review forms and that facility managers monitor compliance.

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 40 randomly selected patients who had a consult requested during an acute care admission from January 1 through June 30, 2014. The table below shows the areas reviewed for this topic. The 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	A committee oversaw the facility's consult management processes.	• In December 2014, the facility chartered a committee to oversee consult management; therefore, there was not yet an ongoing record of actions taken related to consult oversight.	**14.** We recommended that the facility's recently chartered Consult Management Committee meet regularly and document oversight of consult management.
	Major bed services had designated employees to: • Provide training in the use of the computerized consult package • Review and manage consults		
X	Consult requests met selected requirements: • Requestors included the reason for the consult. • Requestors selected the proper consult title. • Consultants appropriately changed consult statuses, linked responses to the requests, and completed consults within the specified timeframe.	• Seven consult requests (18 percent) did not include "inpatient" in the title. • For seven consult requests (18 percent), consultants documented the following inappropriate changes to the consult status—cancelled or acknowledged.	**15.** We recommended that requestors consistently select the proper consult title and that facility managers monitor compliance. **16.** We recommended that consultants do not change the consult request status for inappropriate reasons and that facility managers monitor compliance.
	The facility met any additional elements required by VHA or local policy.		

MRI Safety

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

We reviewed relevant documents and the training records of 48 employees (30 randomly selected Level 1 ancillary staff and 18 designated Level 2 MRI personnel), and we conversed with key managers and employees. We also reviewed the EHRs of 33 randomly selected patients who had an MRI January 1–December 31, 2013. Additionally, we conducted a physical inspection of the MRI 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
	The facility completed an MRI risk assessment, had documented procedures for handling emergencies in MRI, and conducted emergency drills in the MRI area.		
X	Patients had two safety screenings conducted prior to MRI; the patient, family member, or caregiver signed the secondary patient safety screening form; and a Level 2 MRI personnel reviewed and signed the secondary patient safety screening form.	• Four EHRs (12 percent) did not contain secondary patient safety screenings prior to MRI. • Level 2 MRI personnel did not review 21 of the applicable 29 secondary patient safety screening forms prior to MRI.	**17.** We recommended that the facility complete secondary patient safety screenings immediately prior to magnetic resonance imaging and that facility managers monitor compliance. **18.** We recommended that Level 2 magnetic resonance imaging personnel review and sign secondary patient safety screening forms prior to magnetic resonance imaging and that facility managers monitor compliance.
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.	• Thirteen of the applicable 18 EHRs did not contain documentation that a Level 2 MRI personnel and/or radiologist addressed all identified contraindications prior to MRI.	**19.** We recommended that radiologists and/or Level 2 magnetic resonance imaging personnel 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
	The facility designated Level 1 ancillary staff and Level 2 MRI personnel and ensured they received level-specific annual MRI safety training.		
	The facility had signage and barriers in place to prevent unauthorized or accidental access to Zones III and IV.		
	MRI technologists maintained visual contact with patients in the magnet room and two-way communication with patients inside the magnet, and the facility regularly tested the two-way communication device.		
	The facility provided patients with MRI-safe hearing protection for use during the scan.		
	The facility had only MRI-safe or compatible equipment in Zones III and IV or appropriately protected the equipment from the magnet.		
	The facility complied with any additional elements required by VHA or local policy.		

Acute Ischemic Stroke Care

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

We reviewed relevant documents, the EHRs of 37 patients who experienced stroke symptoms, and 15 employee training records (5 Emergency Department, 5 medical intensive care unit, and 5 SICU), and we conversed with key employees. We also conducted onsite inspections of the Emergency Department, the medical intensive care unit, the SICU and one acute inpatient unit. The table below shows the areas reviewed for this topic. The areas marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

NM	Areas Reviewed	Findings	Recommendations
	The facility's stroke policy addressed all required items.		
X	Clinicians completed the National Institutes of Health stroke scale for each patient within the expected timeframe.	• For five patients (14 percent), clinicians did not document evidence of completion of stroke scales.	**20.** We recommended that clinicians complete and document National Institutes of Health stroke scales for each stroke patient and that facility managers monitor compliance.
	Clinicians provided medication (tissue plasminogen activator) timely to halt the stroke and included all required steps, and the facility stocked tissue plasminogen activator in appropriate areas.		
	Facility managers posted stroke guidelines in all areas where patients may present with stroke symptoms.		
X	Clinicians screened patients for difficulty swallowing prior to oral intake of food or medicine.	• For seven patients (19 percent), clinicians did not document in the EHRs that they screened the patients for difficulty swallowing prior to oral intake.	**21.** We recommended that clinicians screen patients for difficulty swallowing prior to oral intake and that facility managers monitor compliance.
	Clinicians provided printed stroke education to patients upon discharge.		

NM	Areas Reviewed (continued)	Findings	Recommendations
	The facility provided training to employees involved in assessing and treating 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.		

Surgical Complexity

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

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

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

EAM

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

We reviewed relevant documents, including competency assessment documentation of 16 clinicians applicable for the review period January 1–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		
	Initial competency assessment for EAM included: • Subject matter content elements and completion of a written test • Successful demonstration of procedural skills on airway simulators or mannequins • Successful demonstration of procedural skills on patients		

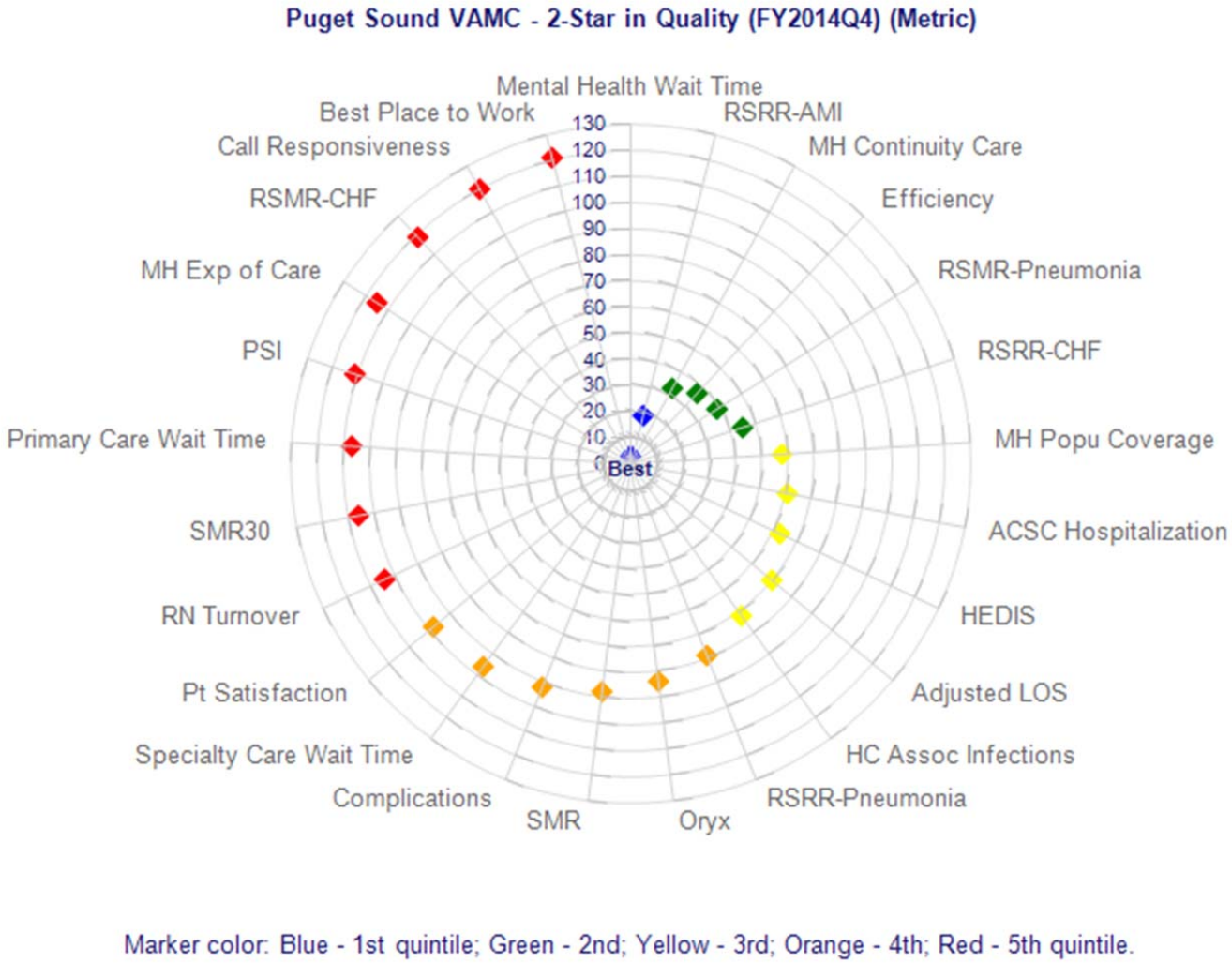
NM	Areas Reviewed (continued)	Findings	Recommendations
X	Reassessments for continued EAM competency were completed at the time of renewal of privileges or scope of practice and included: • Review of clinician-specific EAM data • Subject matter content elements and completion of a written test • Successful demonstration of procedural skills on airway simulators or mannequins • At least one occurrence of successful airway management and intubation in the preceding 2 years, written certification of competency by the supervisor, or successful demonstration of skills to the subject matter expert • A statement related to EAM if the clinician was not a licensed independent practitioner	• None of the thirteen applicable clinicians with reassessments for continued EAM competency had documentation of all required elements at the time of renewal of privileges.	**22.** We recommended that the facility ensure clinician reassessment for continued emergency airway management competency includes all required elements and that facility managers monitor compliance.
	The facility had a clinician with EAM privileges or scope of practice or an anesthesiology staff member available during all hours the facility provided patient care.		
	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 defined that the American Lake division had designated areas where the policy was to call 911 and not perform intubations and required reporting EAM data periodically to a designated committee: • The facility described readiness to perform intubations in the areas designated to call 911. • EAM data was not reported to the designated committee for 12 months.	**23.** We recommended that facility managers ensure the American Lake division follows local emergency airway management policy, or if the facility plans to perform intubations in areas designated to call 911, the facility updates the local emergency airway management policy and ensures privileged providers or clinicians with emergency airway management scope of practice are available. **24.** We recommended that facility managers ensure reporting of emergency airway management data to the designated committee with the frequency required by local policy.

Facility Profile (Seattle/663) FY 2015 through January 2015[1]	
Type of Organization	Tertiary
Complexity Level	1a-High complexity
Affiliated/Non-Affiliated	Affiliated
Total Medical Care Budget in Millions	$671.4
Number (as of February 15, 2015) of:	
• **Unique Patients**	67,933
• **Outpatient Visits**	353,130
• **Unique Employees**[2]	3,300
Type and Number of Operating Beds:	
• **Hospital**	212
• **CLC**	121
• **MH**	64
Average Daily Census:	
• **Hospital**	142
• **CLC**	79
• **MH**	52
Number of Community Based Outpatient Clinics	5
Location(s)/Station Number(s)	King County (Bellevue)/663GA Bremerton/663GB Mount Vernon/663GC South Sound/663GD North Olympic Peninsula/663GE
VISN Number	20

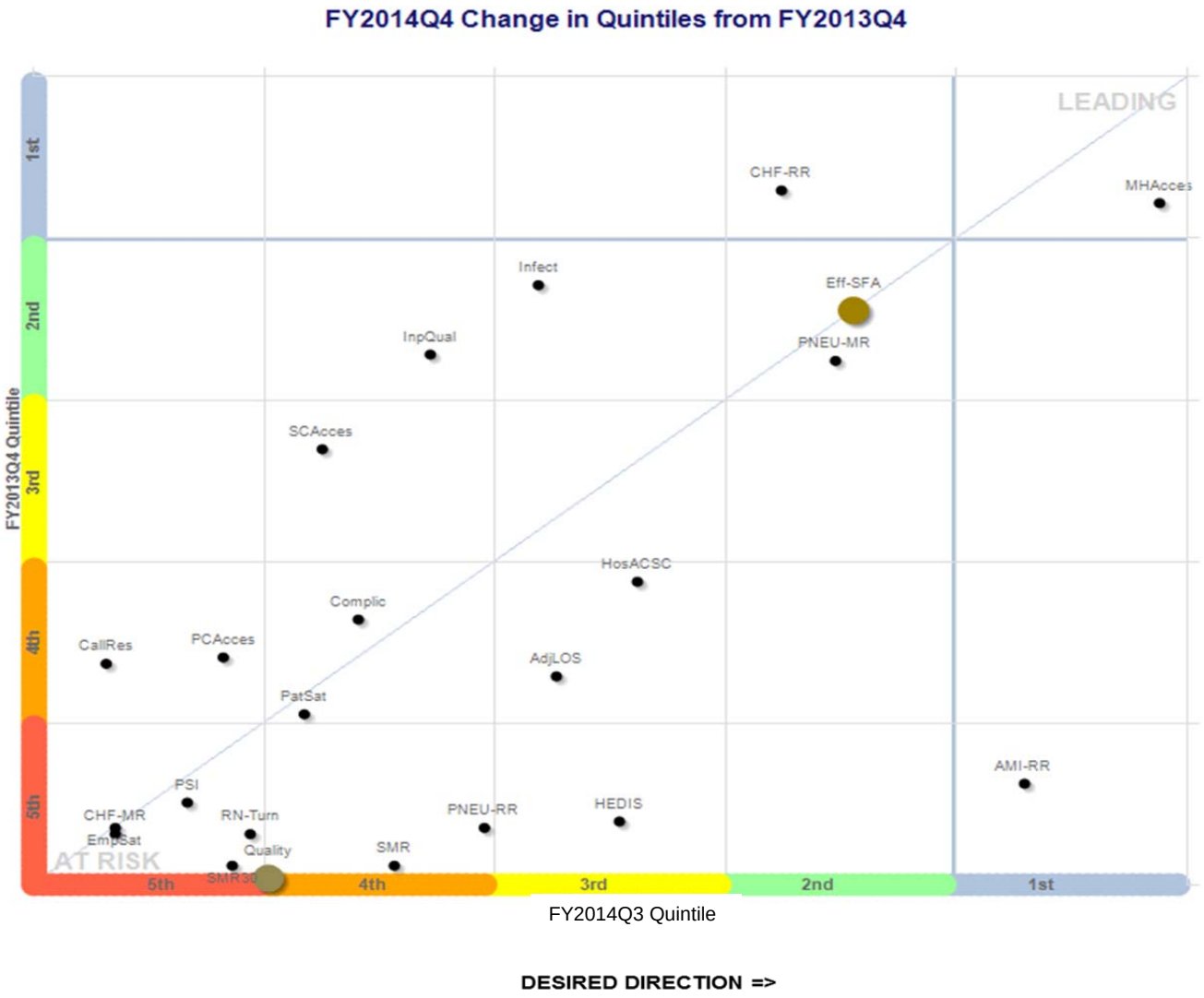
[1] All data is for FY 2015 through January 2015 except where noted.
[2] Unique employees involved in direct medical care (cost center 8200).

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



[3] Metric definitions follow the graphs.

Scatter Chart



DESIRED DIRECTION =>

NOTE

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

Metric Definitions

Measure	Definition	Desired direction
ACSC Hospitalization	Ambulatory care sensitive condition hospitalizations (observed to expected ratio)	A lower value is better than a higher value
Adjusted LOS	Acute care risk adjusted length of stay	A lower value is better than a higher value
Best Place to Work	Overall satisfaction with job	A higher value is better than a lower value
Call Center Responsiveness	Average speed of call center responded to calls in seconds	A lower value is better than a higher value
Call Responsiveness	Call center speed in picking up calls and telephone abandonment rate	A lower value is better than a higher value
Complications	Acute care risk adjusted complication ratio	A lower value is better than a higher value
Efficiency	Overall efficiency measured as 1 divided by SFA (Stochastic Frontier Analysis)	A higher value is better than a lower value
Employee Satisfaction	Overall satisfaction with job	A higher value is better than a lower value
HC Assoc Infections	Health care associated infections	A lower value is better than a higher value
HEDIS	Outpatient performance measure (HEDIS)	A higher value is better than a lower value
MH 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
MH Continuity Care	MH continuity of care (FY14Q3 and later)	MH Continuity Care
MH Exp of Care	MH experience of care (FY14Q3 and later)	A higher value is better than a lower value
MH Popu Coverage	MH population coverage (FY14Q3 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
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

VISN Director Comments

Department of Veterans Affairs

Memorandum

Date: March 19, 2015

From: Director, Northwest Network (10N20)

Subject: **CAP Review of the VA Puget Sound Health Care System, Seattle, WA**

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 respond to the proposed recommendations from the Combined Assessment Program Review of the VA Puget Sound Health Care System, Seattle, WA.

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.

(*original signed by:)*
Lawrence H. Carroll

Attachment

Facility Director Comments

Department of Veterans Affairs

Memorandum

Date: March 11, 2015

From: Director, VA Puget Sound Health Care System (663/00)

Subject: **CAP Review of the VA Puget Sound Health Care System, Seattle, WA**

To: Director, Northwest Network (10N20)

1. Thank you for the opportunity to provide a response to the recommendations from the Combined Assessment Program Review of the VA Puget Sound Health Care System, Seattle, Washington.

2. Attached please find the facility response to each of the findings from the review.

3. If you have questions or need additional information, please contact Jane Penny, Director Quality Improvement at (206-764-5522 or via e-mail Jane.Penny@va.gov.

MJ Murphy

Michael J. Murphy, FACHE

Attachment

Comments to OIG's Report

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

OIG Recommendations

Recommendation 1. We recommended that when cases receive initial Level 2 or 3 ratings, the Peer Review Committee consistently invite involved providers to submit comments to and/or appear before the committee prior to the final level assignment.

Concur

Target date for completion: March 30, 2015

Facility response: The Peer Review Committee (PRC) has ensured that providers in cases with initial level 2 or 3 rating are invited to provide feedback and/or appear before the committee prior to the final level being assigned. This process change has been in effect since February 18, 2014. From February 18, 2014 through March 11, 2015 the Peer Review Committee held twenty-four sessions and has achieved a 100% (46/46) compliance rate where involved providers with an initial rating of level 2 or 3 were invited to submit comments to and/or attend PRC prior to the final level assignment.

Recommendation 2. 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: August 30, 2015

Facility response: The most recent 12 month trend shows a decreasing conversion rate and the facility has a lower rate than the VHA Level 1a facility average rate. The current FY15 year to date average VAPSHCS observation conversion to admission rate is 27.3% which is lower than the FY14 average of 32.7%. The patient flow RN's monitor Veteran admissions to a virtual observation unit daily to ensure compliance with the local policy and utilization management criteria. Each patient admitted to an observation bed is assessed using National Utilization Management Integration (NUMI) criteria. Physician staff is notified of variances and the patient flow RN recommends an alternate level of care. The Patient Flow Manager continuously tracks, trends and analyzes observation conversion rates and reports patient flow data monthly to CEB to ensure conversion rates remain below or equal to the 25% threshold.

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

Concur

Target date for completion: June 1, 2015

Facility response: The Facility Surgical Work Group (FSWG) was restructured to meet the attendance requirements as per VHA Handbook 1102.01 with the Chief of Staff (COS) (or designee) identified as a mandatory attendee. The COS attended the August 25, 2014 Facility Surgical Work Group meeting during which the Charter was reviewed and committee membership outlined. Since this time, the COS attended, or sent a designee, to the Facility Surgical Work Group committee monthly meeting consistently. Between August 25, 2014 and March 1, 2015 the FSWG has held seven sessions. The Chief of Staff attended six sessions for an attendance rate of 86%.

Recommendation 4. We recommended that the Safe Patient Handling Committee track patient handling injury data.

Concur

Target date for completion: March 30, 2015

Facility response: During the first four months of FY15, the VA Puget Sound Health Care System recorded eight injuries related to lifting/repositioning patients. Compared to other 1a complexity facilities, the Seattle VA ranked 12 out of 14 facilities.

The Safe Patient Handing Coordinator provided an analysis of data to the Accident Review Board which identified lifting and repositioning injuries occurring in the following areas: 4 inpatient, 1 offsite, 1 in a public waiting area and 2 injuries in the nursing home care unit. The Safe Patient Handling Coordinator reviews with the Unit Peer Leaders pertinent desensitized injury data quarterly. The Safe Patient Handling Coordinator reports outcomes monthly to the Accident Review Board and the Safety Committee and quarterly to the Environment of Care Board. A quality check is being conducted to assure the new reporting structure is effective and sustained.

Recommendation 5. We recommended the facility ensure a third party conducts quality assurance reviews on a sample of the scanned documents.

Concur

Target date for completion: June 1, 2015

Facility response: The Clinical Documentation Unit (CDU) has worked with Quality Management to develop a new tracking process for scanned documents. A random sample is being examined by the CDU supervisor to ensure image quality and indexing accuracy. An SOP for this process has been developed and implemented. The first quality assurance review will be completed in March 2015 and reported to the Health

Information Review (HIR) Committee. HIR committee will ensure presence of a third party monitor. A quality check will be conducted to confirm third party involvement in the quality assurance reviews. The HIR Committee will take corrective action as needed. Quarterly oversight is provided by the Information Management Board.

Recommendation 6. We recommended that Environment of Care Board and Safety Committee minutes include corrective actions to address identified deficiencies and track those actions to closure.

Target date for completion: June 1, 2015

Facility response: The Quality Consultant and Environment of Care Rounds Coordinator review the deficiency reports from the EOC rounds tracking program prior to each Safety Committee meeting and provides a summary report to the committee. The report now includes:

1. A listing of deficiencies closed within the 14 day turnaround time from rounds conducted between committee meetings;
2. Listings of deficiencies open with current status and work order numbers;
3. Trend reports for the current fiscal year; and
4. Top 5 reported deficiencies for the current fiscal year.

The quality consultant has developed an action plan for ongoing tracking of open action items and presents the status of open deficiencies at the EOC Board meeting with recommendations for follow up. The EOC Board can take corrective action as needed. EOC Board meeting minutes are reviewed quarterly at the Executive Leadership Council.

Recommendation 7. We recommended that facility managers ensure patient care areas and public restrooms are clean and monitor compliance.

Concur

Target date for completion: May 1, 2015

Facility response: Environmental Management Service leadership has developed a cleaning checklist for clinical areas and is continually training all housekeeping staff in proper cleaning standards as needed and when deficiencies are noted. Housekeeping supervisors conduct daily inspections utilizing a tracking checklist and submit the checklist to the Administrative Officer/Quality Consultant. The Housekeeping supervisors provide quality cleaning feedback to area housekeeping aid(s) to ensure sure deficiencies are corrected. Trend reports are shared with the supervisors during monthly meetings. The environmental management leadership conducts spot checks to evaluate clinical areas and provide feedback to the supervisors on the status of each area. The quality consultant has developed a tracking mechanism that identifies deficiencies and provides a weekly report to the Environmental Management Services leadership. Executive Leadership makes observations during weekly walkabouts to ensure conditions are satisfactory. Contact numbers were provided to all facility staff for reporting the need for immediate cleaning.

Recommendation 8. We recommended that facility managers ensure community living center treatment carts containing resident care supplies are clean and monitor compliance.

Concur

Target date for completion: July 2, 2015

Facility response: Treatment carts at the American Lake Community Living Center (CLC) and the Seattle CLC are wiped down daily by the medication nurses to ensure clean drawers and tops. The CLC Nurse Managers monitor during weekly rounds which were initiated March 2015. Weekly monitors for the next three months will continue until 90% compliance is achieved. Executive Leadership makes observations during weekly walkabouts to ensure conditions are satisfactory.

Recommendation 9. We recommended that facility managers ensure critical medical equipment in the community living center is plugged into outlets that function in the event of a power loss and monitor compliance.

Concur

Target date for completion: September 30, 2015

Facility response: Facilities Management assessed the CLCs to determine overall electrical load capacity for emergency outlets. CLC leadership is working with facility management to ensure emergency outlets are consistent regarding location and appearance. CLC managers have re-educated staff regarding protocols to ensure that critical equipment is properly connected on an ongoing basis. Ongoing monitors are in place to ensure all critical equipment is plugged into properly identified emergency outlets. CLC Leadership will monitor weekly during rounds and report compliance to the EOC Board. Weekly observations were initiated March 3, 2015 with 6/6 or 100% compliance for equipment plugged into emergency outlets.

Recommendation 10. We recommended that facility managers ensure emergency crash carts receive checks with the frequency required by local policy and monitor compliance.

Concur

Target date for completion: September 30, 2015

Facility response: Staff have been re-educated to the facility policy provisions for emergency crash cart monitoring. Emergency crash cart checks are accomplished daily by qualified nursing staff. Unit nursing managers monitor crash cart checklists for completion and accuracy and will report compliance monthly to the Critical Care Committee who reports aggregated compliance data quarterly to Clinical Executive Board. The Critical Care Committee recommends corrective action as needed.

Recommendation 11. We recommended that the facility revise the policy for safe use of automated dispensing machines to include oversight of overrides and minimum competency requirements for users and that facility managers monitor compliance.

Concur

Target date for completion: July 1, 2015

Facility response: Policy TX-26, (Operation of Omnicell™ Automated Dispensing Cabinets) has been revised by the Inpatient Pharmacy Manager and recommended for approval by Pharmacy, Nutrition and Therapeutics Committee. It will be forwarded for facility review and concurrence and finalized by the target date. Policy changes will include oversight of overrides and specification of minimum training and competency requirements. The Inpatient Pharmacy Program manager will provide override reports to the unit manager every 2 weeks on an ongoing basis. The unit managers will review override reports for trends, educational needs and any inappropriate use and report to the Nurse Executive Committee who will provide oversight of the process for compliance. Eight out of 8 units, including the ICUs, med-surg, and CLC will show evidence that Nurse Managers have reviewed the override report for a 3 month period.

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

Concur

Target date for completion: July 1, 2015

Facility response: Training regarding automated dispensing machines has been initiated for all designated employees. 95 % will have completed training by the target date. A new competency form is being developed to assess automated dispensing machine competency through return demonstration and observation. Utilizing a competency skills checklist, each employee/new user will demonstrate 100% skill accuracy verified through observation. Using areas will complete the automated dispensing machine competency assessment by the target date. Eight units, including the ICUs, ED, med-surg and CLC units will be monitored for compliance on completion of competency. Unit managers will ensure staff competency assessment is completed and a progress report will be provided monthly to the Nurse Executive Committee until a 95 % compliance rate is obtained for each of the 8 units.

Recommendation 13. We recommended that nursing reviewers sign the monthly medication review forms and that facility managers monitor compliance.

Concur

Target date for completion: July 1, 2015

Facility response: Pharmacy technicians were reminded by the Pharmacy Program Managers at meetings completed by Feb 15 that the unit manager's signature was required on the monthly inspection forms. Nursing staff in the Intensive Care Units and the Operating Room were also reminded of the facility policy regarding signatory obligations. The monthly inspection form will be checked in 10 units inspected for a 3 month period (representing units at both divisions) to verify that 100% (10/10 units) had all elements completed, including the nurse reviewer section. Pharmacy Managers will monitor facility medication inspection forms for completion and will report compliance to the Nurse Executive Committee.

Recommendation 14. We recommended that the facility's recently chartered Consult Management Committee meet regularly and document oversight of consult management.

Concur

Target date for completion: December 15, 2015

Facility response: The Consult Management Committee charter was developed and implemented December 2014. Clinical service lines are well represented and a committee chair and co-chair are in place. This committee meets monthly and reports quarterly to the Clinical Executive Board. The meeting minutes and reports will document oversight of consult management. The Consult Management Committee takes corrective actions as needed.

Recommendation 15. We recommended that requestors consistently select the proper consult title and that facility managers monitor compliance.

Concur

Target date for completion: July 1, 2015

Facility response: The Consult Management Committee and the Access Wednesday workgroup have initiated refresher training on proper consult titles for requesting providers March 2015. Health Information Management (HIM) monitors inpatient vs. outpatient consult service requests through the Health Information Review (HIR) process with individual and service specific reporting. Discussion and request for educational opportunities is documented in the February 2015 Consult Management Committee meeting minutes. Preliminary data suggests additional training is having a positive impact on selection of appropriate consult titles. Monthly data will be reported to the Health Information Review (HIR) Committee and the Consult Management Committee. The Consult Management Committee will take corrective action as needed. Quarterly oversight is provided by the Executive Leadership Council.

Recommendation 16. We recommended that consultants do not change the consult request status for inappropriate reasons and that facility managers monitor compliance.

Concur

Target date for completion: July 1, 2015

Facility response: The facility Consult Management Committee has discussed the need to ensure staff use only the discontinue option for inpatient consults, not cancellation, if a consult will not be completed. The facility monitors and tracks disposition of consult requests through the HIR Committee to assure Veteran received appropriate care as requested. Initial discussions and reviews are documented in the Consult Management Committee minutes from February and March 2015. Greater than 90% of Inpatient consults will be completed within 3 working days. Reasons why consults were discontinued and all cancelled consults will be evaluated to ensure all appropriate care is provided.

Recommendation 17. We recommended that the facility complete secondary patient safety screenings immediately prior to magnetic resonance imaging and that facility managers monitor compliance.

Concur

Target date for completion: August 30, 2015

Facility response: Secondary patient safety screens are completed by level 2 MRI personnel and scanned into the electronic medical record. A routing cover sheet has been implemented by Diagnostic Imaging staff to ensure each safety screen is uploaded. The Chief Technologist has educated staff on the new cover sheet effective March 6. A review of 30 records for a 3 month period will be completed by the target date to ensure 90% compliance and will be reported to the MRI Committee. The MRI Committee will take corrective action when needed. Oversight for facility monitoring compliance will be done quarterly by the Leadership Quality Management Review (LQMR).

Recommendation 18. We recommended that Level 2 magnetic resonance imaging personnel review and sign secondary patient safety screening forms prior to magnetic resonance imaging and that facility managers monitor compliance.

Concur

Target date for completion: August 30, 2015

Facility response: Level 2 MRI personnel have been instructed by the Chief Technologist, effective February 2, to print their names on the screening forms in addition to signing the forms. Screening forms are being modified to provide a pre-printed name of the MRI Level 2 personnel to assure legibility. A review of 30 records for a 3 month period will be completed by the target date to ensure

90% compliance and will be reported to the MRI Committee. The MRI Committee will take corrective action when needed. Oversight for facility monitoring compliance will be done quarterly by the Leadership Quality Management Review (LQMR).

Recommendation 19. We recommended that radiologists and/or Level 2 magnetic resonance imaging personnel 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: September 30, 2015

Facility response: A Computer Application Coordinator (CAC) has developed a new CPRS draft template in coordination with Diagnostic Imaging leadership to document resolution of contraindications in CPRS. Once the draft template is finalized, staff will be trained on its use. A review of 30 records for a 3 month period will be completed by the target date to ensure 90% compliance and will be reported to the MRI Committee. The MRI Committee will take corrective action when needed. Oversight for facility monitoring compliance will be done quarterly by the Leadership Quality Management Review (LQMR).

Recommendation 20. 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: July 31 2015

Facility response: The acute stroke admission template has been updated with a time stamp to document compliance with the National Institutes of Health stroke scales (NIHSS). The Stroke Center Medical Director and Co-Director:

A. Have educated nurses, neurology residents and NIHSS certified providers that the NIHSS scores must be performed and documented in computerized patient record (CPRS) within 3 hours; and

Will evaluate stroke cases for compliance and report monthly aggregated data to the Stroke Advisory Committee and quarterly aggregated data to the Clinical Executive Board. The Stroke Advisory Committee will take corrective action when needed.

Recommendation 21. We recommended that clinicians screen patients for difficulty swallowing prior to oral intake and that facility managers monitor compliance.

Concur

Target date for completion: July 31, 2015

Facility response: The Stroke Center Medical Director and Co-director:

A. Have educated Emergency Department physicians and nurses to ensure the swallow screen is completed prior to oral intake;
B. Will ensure a swallow screen assessment is repeated when a Veteran is moved from one hospital unit to another unit or if a Veteran has an acute ischemic stroke as an inpatient; and
C. Will monitor and analyze swallow assessment documentation data in CPRS and report monthly variances to the Stroke Advisory Committee and quarterly to the Clinical Executive Board. The Stroke Advisory Committee will take corrective action when needed.

Recommendation 22. 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: March 30, 2015

Facility response: The Emergency Airway Management (EAM) provider competency training program is coordinated, implemented and monitored by the Chief of Anesthesia. EAM provider competency tracking is integrated with the Credentialing and Privileging (C&P) Office. Providers who had been granted EAM privileges prior to implementation of this program (without having completed certification) have had their EAM privileges suspended until satisfactory completion of EAM process. The Chief of Anesthesia now verifies the provider candidate has completed all required elements of the competency prior to recommendation of privilege renewal. An inter-departmental tracking checklist was implemented to ensure EAM training requirements are coordinated with C&P during each privileged provider renewal cycle. Eleven providers have current EAM privileges and eleven EAM Privileged providers have completed all required elements of the competency program. (11/11 or 100%)

Recommendation 23. We recommended that facility managers ensure the American Lake division follows local emergency airway management policy, or if the facility plans to perform intubations in areas designated to call 911, the facility updates the local emergency airway management policy and ensures privileged providers or clinicians with emergency airway management scope of practice are available.

Concur

Target date for completion: March 30, 2015

Facility response: EAM certified providers are available “in house” to support the GI lab during moderate sedation procedures. The emergency airway management policy has been updated by the Chief of Anesthesia to include language for the American Lake facility which ensures privileged providers with emergency airway management

privileges are available during hours of operations when GI moderate sedation procedures are being performed.

Recommendation 24. We recommended that facility managers ensure reporting of emergency airway management data to the designated committee with the frequency required by local policy.

Concur

Target date for completion: July 31, 2015

Facility response: The CPR Committee reviews 100% of emergency airway management cases. Data including adverse outcomes from airway management and any associated process or equipment issues are considered monthly. The facility policy has been updated to reflect this monitoring cycle. The CPR Committee will take corrective actions as needed. The CPR Committee reports quarterly to the Clinical Executive Board.

Office of Inspector General
Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the OIG at (202) 461-4720.
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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] References used for this topic included:
- VHA Handbook 1105.05, *Magnetic Resonance Imaging Safety*, July 19, 2012.
- Emanuel Kanal, MD, et al., "ACR Guidance Document on MR Safe Practices: 2013," *Journal of Magnetic Resonance Imaging*, Vol. 37, No. 3, January 23, 2013, pp. 501–530.
- The Joint Commission, "Preventing accidents and injuries in the MRI suite," Sentinel Event Alert, Issue 38, February 14, 2008.
- VA National Center for Patient Safety, "MR Hazard Summary," http://www.patientsafety.va.gov/professionals/hazards/mr.asp.
- VA Radiology, "Online Guide," http://vaww1.va.gov/RADIOLOGY/OnLine_Guide.asp, updated October 4, 2011.

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

[g] References used for this topic included:
- VHA Directive 2009-001, *Restructuring of VHA Clinical Programs*, January 5, 2009.
- VHA Directive 2010-018, *Facility Infrastructure Requirements to Perform Standard, Intermediate, or Complex Surgical Procedures*, May 6, 2010.

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