
**Department of Veterans Affairs**
**Office of Inspector General**

**Office of Healthcare Inspections**

**Report No. 16-00104-230**

# Combined Assessment Program Review of the Fargo VA Health Care System Fargo, North Dakota

**April 6, 2016**

**Washington, DC 20420**

**To Report Suspected Wrongdoing in VA Programs and Operations**
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# Glossary

| | |
|---|---|
| AD | advance directive |
| CAP | Combined Assessment Program |
| CSP | compounded sterile product |
| CT | computed tomography |
| EHR | electronic health record |
| EOC | environment of care |
| facility | Fargo VA Health Care System |
| FY | fiscal year |
| MH | mental health |
| NA | not applicable |
| NM | not met |
| OIG | Office of Inspector General |
| OR | operating room |
| QSV | quality, safety, and value |
| VHA | Veterans Health Administration |

# Table of Contents

# Executive Summary

**Review Purpose:** The purpose of the review was to evaluate selected health care facility operations, focusing on patient care quality and the environment of care. We conducted the review the week of January 25, 2016.

**Review Results:** The review covered seven activities. We made no recommendations in the following three activities:

- Quality, Safety, and Value
- Environment of Care
- Computed Tomography Radiation Monitoring

The facility's reported accomplishments were the implementation of the GetWell Network and a transformative nursing initiative incorporating a holistic nursing scope of practice.

**Recommendations:** We made recommendations in the following four activities:

*Medication Management:* Ensure that competency assessment for employees who prepare compounded sterile products includes gloved fingertip sampling and that all compounded sterile product labels contain the preparer and checker initials and the beyond use date.

*Coordination of Care:* Consistently document discharge progress notes or instructions that include all required elements.

*Advance Directives:* Ask inpatients whether they would like to discuss creating, changing, and/or revoking advance directives.

*Suicide Prevention Program:* Ensure new clinical employees complete suicide risk management training within the required timeframe. Include in Suicide Prevention Safety Plans documentation of assessment of available lethal means and how to keep the environment safe.

## Comments

The Acting Veterans Integrated Service Network Director and Facility Director agreed with the Combined Assessment Program review findings and recommendations and provided acceptable improvement plans. (See Appendixes C and D, pages 24–27, for

the full text of the Directors' comments.) We consider recommendation 2 closed. We will follow up on the planned actions for the open recommendations until they are completed.

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

# 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 seven activities:

- QSV
- EOC
- Medication Management
- Coordination of Care
- CT Radiation Monitoring
- ADs
- Suicide Prevention Program

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

The review covered facility operations for FY 2014, FY 2015, FY 2016 through January 29, 2016, and inspectors conducted the review 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 Fargo VA Health Care System, Fargo, North Dakota,* Report No. 13-01973-288, August 26, 2013).

Additionally, we surveyed employees regarding patient safety and quality of care at the facility. We distributed an electronic survey to all facility employees and received 283 responses. We shared summarized results with the Facility Director.

In this report, we make recommendations for improvement. Recommendations pertain to issues that are significant enough for the OIG to monitor until the facility implements corrective actions.

# Reported Accomplishments

## GetWell Network

The patient has a vital role in making his/her hospital stay a safe one by becoming an active, involved, and informed member of the health care team. At the facility, patients can be active participants in their care through the television in their room, which is equipped with the GetWell Network system. Through the remote control, keyboard, or touch screen monitor, this innovative system provides access to communication tools; informational guides; *MyHealtheVet*; education; the internet; and entertainment resources such as television, music, and movies. Other features include nursing established order sets of previewed educational material to facilitate patient learning needs, a Facility Director welcome for each admitted patient, and comfort and sleep menus to support patients in selecting available interventions and healing therapies to aid in comfort and sleep. The GetWell Network is also equipped with real time satisfaction surveys, and responses are tracked and evaluated for improvements. Improvements have included more chairs in patient rooms, better room temperature monitoring, noise reduction efforts, and enhanced communication through daily interdisciplinary rounds at the bedside and nurse change of shift reports at the bedside.

## Transformative Nursing

The facility began an initiative to integrate healing philosophies, principles, and therapy practices into the nursing care delivery system. The initiative incorporates a holistic nursing scope of practice that emphasizes whole patient, patient-centered integrative health practices toward healing and engaging the patient's mind, body, and spirit. This initiative is intended to transform health care through daily access to nursing delivered integrative therapies to enhance patient wellness and reduce mind-body stress, which often presents as anxiety; pain; and changes in sleep, eating, and physical energy. Therapy provided by nursing employees includes energy healing techniques, relaxation, massage, acupressure, and aromatherapy. There has been positive feedback from patients and families on the impact of the healing therapies. It has been specifically noted as something that made patients feel better and more satisfied.

# Results and Recommendations

## QSV

The purpose of this review was to determine whether the facility complied with selected QSV program requirements.[a]

We conversed with senior managers and key QSV employees, and we evaluated meeting minutes, 20 licensed independent practitioners' profiles, 15 protected peer reviews, 5 root cause analyses, and other relevant documents. 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 |
|---|---|---|---|
| | There was a senior-level committee responsible for key QSV functions that met at least quarterly and was chaired or co-chaired by the Facility Director.<br>• The committee routinely reviewed aggregated data. | | |
| | Credentialing and privileging processes met selected requirements:<br>• Facility policy/by-laws addressed a frequency for clinical managers to review practitioners' Ongoing Professional Practice Evaluation data.<br>• Facility clinical managers reviewed Ongoing Professional Practice Evaluation data at the frequency specified in the policy/by-laws.<br>• The facility set triggers for when a Focused Professional Practice Evaluation for cause would be indicated.<br>• The facility followed its policy when employees' licenses expired. | | |

| NM | Areas Reviewed (continued) | Findings | Recommendations |
|---|---|---|---|
| | Protected peer reviews met selected requirements:<br>• Peer reviewers documented their use of important aspects of care in their review such as appropriate and timely ordering of diagnostic tests, timely treatment, and appropriate documentation.<br>• When the Peer Review Committee recommended individual improvement actions, clinical managers implemented the actions. | | |
| | Utilization management met selected requirements:<br>• The facility completed at least 75 percent of all required inpatient reviews.<br>• Physician Utilization Management Advisors documented their decisions in the National Utilization Management Integration database.<br>• The facility had designated an interdisciplinary group to review utilization management data. | | |
| | Patient safety met selected requirements:<br>• The Patient Safety Manager entered all reported patient incidents into the WEBSPOT database.<br>• The facility completed the required minimum of eight root cause analyses.<br>• The facility provided feedback about the root cause analysis findings to the individual or department who reported the incident.<br>• At the completion of FY 2015, the Patient Safety Manager submitted an annual patient safety report to facility leaders. | | |

| NM | Areas Reviewed (continued) | Findings | Recommendations |
|---|---|---|---|
| | Overall, if QSV reviews identified significant issues, the facility took actions and evaluated them for effectiveness. | | |
| | Overall, senior managers actively participated in QSV activities. | | |
| | The facility met any additional elements required by VHA or local policy. | | |

## EOC

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

We inspected the community living center; inpatient intensive care, medicine/surgical, and MH units; Emergency Department; OR; and primary care, ophthalmology, cardiology, specialty, and dental clinics. Additionally, we reviewed relevant documents and 10 employee training records, and we conversed with key employees and managers. The table below shows the areas reviewed for this topic. Any items that did not apply to this facility are marked NA. The facility generally met requirements. We made no recommendations.

| NM | Areas Reviewed for General EOC | Findings | Recommendations |
|---|---|---|---|
| | EOC Committee minutes reflected sufficient detail regarding identified deficiencies, corrective actions taken, and tracking of corrective actions to closure for the facility and the community based outpatient clinics. | | |
| | The facility conducted an infection prevention risk assessment. | | |
| | Infection Prevention/Control Committee minutes documented discussion of identified high-risk areas, actions implemented to address those areas, and follow-up on implemented actions and included analysis of surveillance activities and data. | | |
| | The facility had established a process for cleaning equipment between patients. | | |
| | The facility conducted required fire drills in buildings designated for health care occupancy and documented drill critiques. | | |
| | The facility had a policy/procedure/guideline for identification of individuals entering the facility, and units/areas complied with requirements. | | |
| | The facility met fire safety requirements. | | |

| NM | Areas Reviewed for General EOC (continued) | Findings | Recommendations |
|---|---|---|---|
| | The facility met environmental safety requirements. | | |
| | 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 Dental Clinic** | | |
| | Dental clinic employees completed bloodborne pathogens training within the past 12 months. | | |
| | Dental clinic employees received hazard communication training on chemical classification, labeling, and safety data sheets. | | |
| NA | Designated dental clinic employees received laser safety training in accordance with local policy. | | |
| | The facility tested dental water lines in accordance with local policy. | | |
| | The facility met environmental safety and infection prevention requirements in the dental clinic. | | |
| NA | The facility met laser safety requirements in the dental clinic. | | |
| | The facility complied with any additional elements required by VHA, local policy, or other regulatory standards. | | |

| NM | Areas Reviewed for the OR | Findings | Recommendations |
|---|---|---|---|
| | The facility had emergency fire policy/procedures for the OR that included alarm activation, evacuation, and equipment shutdown with responsibility for turning off room or zone oxygen. | | |
| | The facility had cleaning policy/procedures for the OR and adjunctive areas that included a written cleaning schedule and methods of decontamination. | | |
| NA | OR housekeepers received training on OR cleaning/disinfection in accordance with local policy. | | |
| | The facility monitored OR temperature, humidity, and positive pressure. | | |
| | The facility met fire safety requirements in the OR. | | |
| | The facility met environmental safety requirements in the OR. | | |
| | The facility met infection prevention requirements in the OR. | | |
| | The facility met medication safety and security requirements in the OR. | | |
| NA | The facility met laser safety requirements in the OR. | | |
| | The facility complied with any additional elements required by VHA, local policy, or other regulatory standards. | | |

## Medication Management

The purpose of this review was to determine whether the facility complied with selected requirements for the safe preparation of CSPs.[c]

We reviewed relevant documents and the competency assessment/testing records of 10 pharmacy employees (5 pharmacists and 5 technicians). Additionally, we inspected the one area where sterile products are compounded. 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 policy on preparation of CSPs that included required components:<br>• Pharmacist CSP preparation or supervision of preparation except in urgent situations<br>• Hazardous CSP preparation in an area separate from routine CSP preparation or in a compounding aseptic containment isolator<br>• Environmental quality and control of ante and buffer areas<br>• Hood certification initially and every 6 months thereafter<br>• Cleaning procedures for all surfaces in the ante and buffer areas | | |
| X | The facility established competency assessment requirements for employees who prepare CSPs that included required elements, and facility managers assessed employee competency at the required frequency based on the facility's risk level. | • Facility competency assessment for employees who prepare CSPs did not include gloved fingertip sampling. | **1.** We recommended that facility managers ensure competency assessment for employees who prepare compounded sterile products includes gloved fingertip sampling. |

| NM | Areas Reviewed (continued) | Findings | Recommendations |
|---|---|---|---|
| | If the facility used an outsourcing facility for CSPs, it had a policy/guidelines/a plan that included required components for the outsourcing facility:<br>• Food and Drug Administration registration<br>• Current Drug Enforcement Agency registration if compounding controlled substances | | |
| | The facility had a safety/competency assessment checklist for preparation of CSPs that included required steps in the proper order to maintain sterility. | | |
| | All International Organization for Standardization classified areas had documented evidence of periodic surface sampling, and the facility completed required actions when it identified positive cultures. | | |
| | The facility had a process to track and report CSP medication errors, including near misses. | | |
| | The facility met design and environmental safety controls in compounding areas. | | |
| | The facility used a laminar airflow hood or compounding aseptic isolator for preparing non-hazardous intravenous admixtures and any sterile products. | | |
| | The facility used a biological safety cabinet in a physically separated negative pressure area or a compounding aseptic containment isolator for hazardous medication compounding and had sterile chemotherapy type gloves available for compounding these medications. | | |

| NM | Areas Reviewed (continued) | Findings | Recommendations |
|---|---|---|---|
| | If the facility prepared hazardous CSPs, a drug spill kit was available in the compounding area and during transport of the medication to patient care areas. | | |
| | Hazardous CSPs were physically separated or placed in specially identified segregated containers from other inventory to prevent contamination or personnel exposure. | | |
| | An eyewash station was readily accessible near hazardous medication compounding areas, and there was documented evidence of weekly testing. | | |
| | The facility documented cleaning of compounding areas, and employees completed cleaning at required frequencies. | | |
| | During the past 12 months, the facility initially certified new hoods and recertified all hoods minimally every 6 months. | | |
| X | Prepared CSPs had labels with required information prior to delivery to the patient care areas:<br>• Patient identifier<br>• Date prepared<br>• Admixture components<br>• Preparer and checker identifiers<br>• Beyond use date | • None of the three CSP labels reviewed contained the preparer or checker initials or the beyond use date. | **2.** We recommended that facility managers ensure all compounded sterile product labels contain the preparer and checker initials and the beyond use date. |
| | The facility complied with any additional elements required by VHA, local policy, or other regulatory standards. | | |

## Coordination of Care

The purpose of this review was to evaluate selected aspects of the facility's patient flow process over the inpatient continuum (admission through discharge).[d]

We reviewed relevant documents and conversed with key employees. Additionally, we reviewed the EHRs of 33 randomly selected patients who had an acute care inpatient stay of at least 3 days from July 1, 2014, through June 30, 2015. 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 |
|---|---|---|---|
| | The facility had a policy that addressed patient discharge and scheduling discharges early in the day. | | |
| | The facility had a policy that addressed temporary bed locations, and it included:<br>• Priority placement for inpatient beds given to patients in temporary bed locations<br>• Upholding the standard of care while patients are in temporary bed locations<br>• Medication administration<br>• Meal provision | | |
| | The Facility Director had appointed a Bed Flow Coordinator with a clinical background. | | |
| | Physicians or acceptable designees completed a history and physical exam within 1 day of the patient's admission or referenced a history and physical exam completed within 30 days prior to admission.<br>• When resident physicians completed the history and physical exams, the attending physicians provided a separate admission note or addendum within 1 day of the admission. | | |

| NM | Areas Reviewed (continued) | Findings | Recommendations |
|---|---|---|---|
| | • When the facility policy and/or scopes of practice allowed for physician assistants or nurse practitioners to complete history and physical exams, they were properly documented. | | |
| | Nurses completed admission assessments within 1 day of the patient's admission. | | |
| | When patients were transferred during the inpatient stay, physicians or acceptable designees documented transfer notes within 1 day of the transfer.<br>• When resident physicians wrote the transfer notes, attending physicians documented adequate supervision.<br>• Receiving physicians documented transfers. | | |
| | When patients were transferred during the inpatient stay, sending and receiving nurses completed transfer notes. | | |
| X | Physicians or acceptable designees documented discharge progress notes or instructions that included patient diagnoses, discharge medications, and follow-up activity levels.<br>• When resident physicians completed the discharge notes/instructions, attending physicians documented adequate supervision.<br>• When facility policy and/or scopes of practice allowed for physician assistants or nurse practitioners to complete discharge notes/instructions, they were properly documented. | • For 25 of the 26 applicable EHRs, physician documented discharge progress notes or instructions did not include all required elements. | **3.** We recommended that physicians consistently document discharge progress notes or instructions that include all required elements and that facility managers monitor compliance. |

| NM | Areas Reviewed (continued) | Findings | Recommendations |
|---|---|---|---|
| | Clinicians provided discharge instructions to patients and/or caregivers and documented patients and/or caregiver understanding. | | |
| | The facility complied with any additional elements required by VHA or local policy. | | |

## CT Radiation Monitoring

The purpose of this review was to determine whether the facility complied with selected VHA radiation safety requirements and to follow up on recommendations regarding monitoring and documenting radiation dose from a 2011 report, *Healthcare Inspection – Radiation Safety in Veterans Health Administration Facilities*, Report No. 10-02178-120, March 10, 2011.[e]

We reviewed relevant documents, including qualifications and dosimetry monitoring for nine CT technologists and CT scanner inspection reports, and we conversed with key managers and employees. We also reviewed the EHRs of 50 randomly selected patients who had a CT scan January 1–December 31, 2014. The table below shows the areas reviewed for this topic. Any items that did not apply to this facility are marked NA. The facility generally met requirements. We made no recommendations.

| NM | Areas Reviewed | Findings | Recommendations |
|---|---|---|---|
| | The facility had a designated Radiation Safety Officer responsible for oversight of the radiation safety program. | | |
| | The facility had a CT/imaging/radiation safety policy or procedure that included:<br>• A CT quality control program with program monitoring by a medical physicist at least annually, image quality monitoring, and CT scanner maintenance<br>• CT protocol monitoring to ensure doses were as low as reasonably achievable and a method for identifying and reporting excessive CT patient doses to the Radiation Safety Officer<br>• A process for managing/reviewing CT protocols and procedures to follow when revising protocols<br>• Radiologist review of appropriateness of CT orders and specification of protocol prior to scans | | |

| NM | Areas Reviewed (continued) | Findings | Recommendations |
|---|---|---|---|
| | A radiologist and technologist expert in CT reviewed all CT protocols revised during the past 12 months. | | |
| | A medical physicist tested a sample of CT protocols at least annually. | | |
| | A medical physicist performed and documented CT scanner annual inspections, an initial inspection after acquisition, and follow-up inspections after repairs or modifications affecting dose or image quality prior to the scanner's return to clinical service. | | |
| | If required by local policy, radiologists included patient radiation dose in the CT report available for clinician review and documented the dose in the required application(s), and any summary reports provided by teleradiology included dose information. | | |
| | CT technologists had required certifications or written affirmation of competency if "grandfathered in" prior to January 1987, and technologists hired after July 1, 2014, had CT certification. | | |
| | There was documented evidence that CT technologists had annual radiation safety training and dosimetry monitoring. | | |
| | If required by local policy, CT technologists had documented training on dose reduction/optimization techniques and safe procedures for operating the types of CT equipment they used. | | |
| | The facility complied with any additional elements required by VHA or local policy. | | |

## ADs

The purpose of this review was to determine whether the facility complied with selected requirements for ADs for patients.[f]

We reviewed relevant documents and conversed with key employees. Additionally, we reviewed the EHRs of 34 randomly selected patients who had an acute care admission July 1, 2014, through June 30, 2015. 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 |
|---|---|---|---|
| | The facility had an AD policy that addressed:<br>• AD notification, screening, and discussions<br>• Proper use of AD note titles | | |
| | Employees screened inpatients to determine whether they had ADs and used appropriate note titles to document screening. | | |
| | When patients provided copies of their current ADs, employees had scanned them into the EHR.<br>• Employees correctly posted patients' AD status. | | |
| X | Employees asked inpatients if they would like to discuss creating, changing, and/or revoking ADs. | • Eleven of the 32 applicable EHRs (34 percent) did not contain documentation that employees asked inpatients whether they wished to discuss creating, changing, and/or revoking their ADs. | **4.** We recommended that employees ask inpatients whether they would like to discuss creating, changing, and/or revoking advance directives and that facility manager's monitor compliance. |
| | The facility met any additional elements required by VHA or local policy. | | |

## Suicide Prevention Program

The purpose of this review was to evaluate the extent the facility's MH providers consistently complied with selected suicide prevention program requirements.[g]

We reviewed relevant documents and conversed with key employees. Additionally, we reviewed the EHRs of 41 patients assessed to be at risk for suicide during the period October 1, 2014–September 30, 2015, plus those who died from suicide during this same timeframe. We also reviewed the training records of 15 new 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.

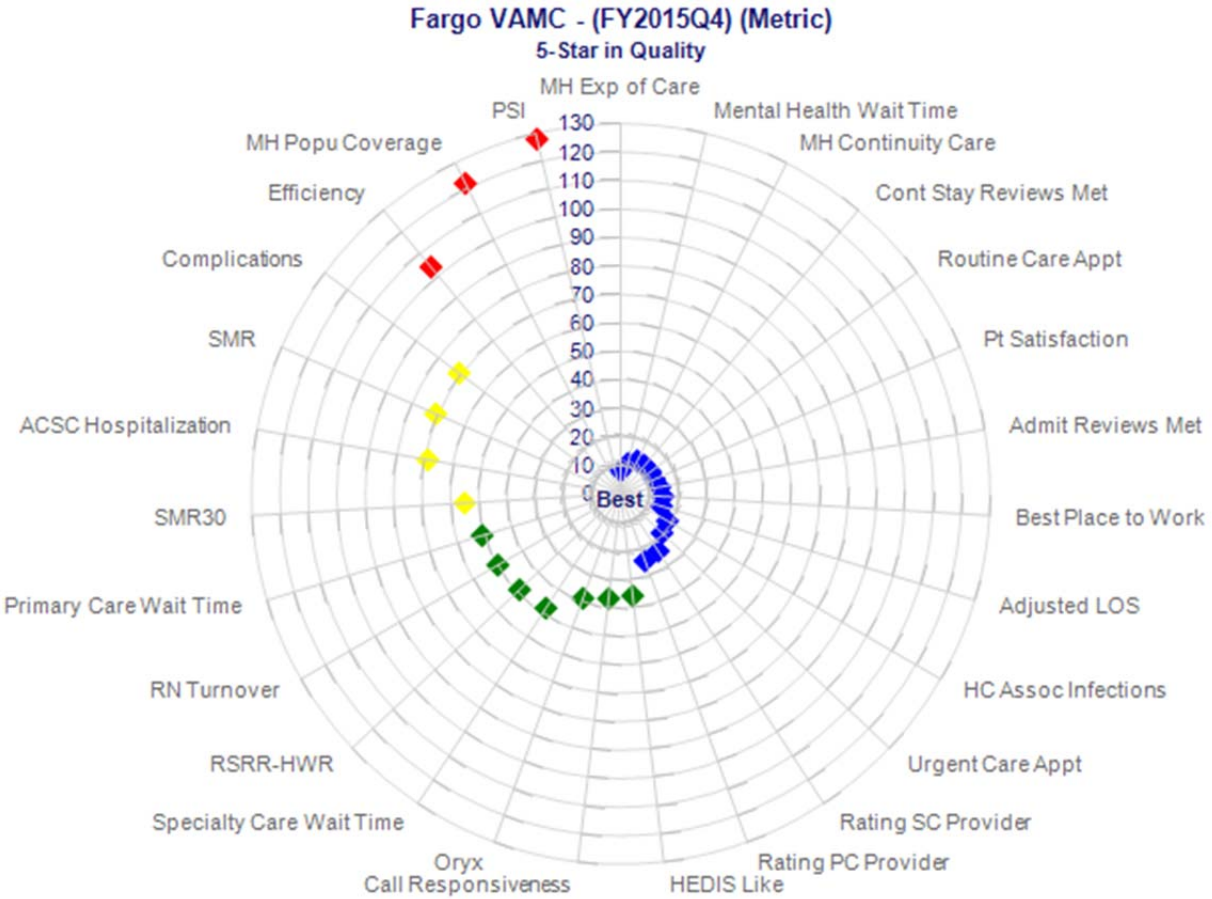
| NM | Areas Reviewed | Findings | Recommendations |
|---|---|---|---|
| | The facility had a full-time Suicide Prevention Coordinator. | | |
| | The facility had a process for responding to referrals from the Veterans Crisis Line and for tracking patients who are at high risk for suicide. | | |
| | The facility had a process to follow up on high-risk patients who missed MH appointments. | | |
| X | The facility provided training within required timeframes:<br>• Suicide prevention training to new employees<br>• Suicide risk management training to new clinical employees | • Nine of the 10 applicable training records indicated that clinicians did not complete suicide risk management training within 90 days of being hired. | **5.** We recommended that the facility ensure new clinical employees complete suicide risk management training within the required timeframe and that facility managers monitor compliance. |
| | The facility provided at least five suicide prevention outreach activities to community organizations each month. | | |
| | The facility completed required reports and reviews regarding patients who attempted or completed suicide. | | |

| NM | Areas Reviewed (continued) | Findings | Recommendations |
|---|---|---|---|
| | Clinicians assessed patients for suicide risk at the time of admission. | | |
| | Clinicians appropriately placed Patient Record Flags:<br>• High-risk patients received Patient Record Flags.<br>• Moderate- and low-risk patients did not receive Patient Record Flags. | | |
| X | Clinicians documented Suicide Prevention Safety Plans that contained the following required elements:<br>• Identification of warning signs<br>• Identification of internal coping strategies<br>• Identification of contact numbers of family or friends for support<br>• Identification of professional agencies<br>• Assessment of available lethal means and how to keep the environment safe | • Six of 21 safety plans lacked documentation of assessment of available lethal means and how to keep the environment safe. | **6.** We recommended that clinicians include documentation of assessment of available lethal means and how to keep the environment safe in Suicide Prevention Safety Plans and that facility managers monitor compliance. |
| | Clinicians documented that they gave patients and/or caregivers a copy of the safety plan. | | |
| | The treatment team evaluated patients as follows:<br>• At least four times during the first 30 days after discharge<br>• Every 90 days to review Patient Record Flags | | |
| | The facility complied with any additional elements required by VHA or local policy. | | |

| Facility Profile (Fargo/437) FY 2016 through December 2015 | |
|---|---|
| **Type of Organization** | Secondary |
| **Complexity Level** | 2-Medium complexity |
| **Affiliated/Non-Affiliated** | Affiliated |
| **Total Medical Care Budget in Millions** | $50.9 |
| **Number of:** | |
| • **Unique Patients** | 20,702 |
| • **Outpatient Visits** | 75,745 |
| • **Unique Employees**[1] | 920 |
| **Type and Number of Operating Beds:** | |
| • **Hospital** | 37 |
| • **Community Living Center** | 28 |
| • **Domiciliary** | 10 |
| **Average Daily Census:** | |
| • **Hospital** | 17 |
| • **Community Living Center** | 25 |
| • **Domiciliary** | 4 |
| **Number of Community Based Outpatient Clinics** | 7 |
| **Location(s)/Station Number(s)** | Grafton/437GA<br>Bismarck/437GB<br>Fergus Falls/437GC<br>Minot/437GD<br>Bemidji/437GE<br>Williston/437GF<br>Grand Forks/437GI |
| **Veterans Integrated Service Network Number** | 23 |

[1] Unique employees involved in direct medical care (cost center 8200).

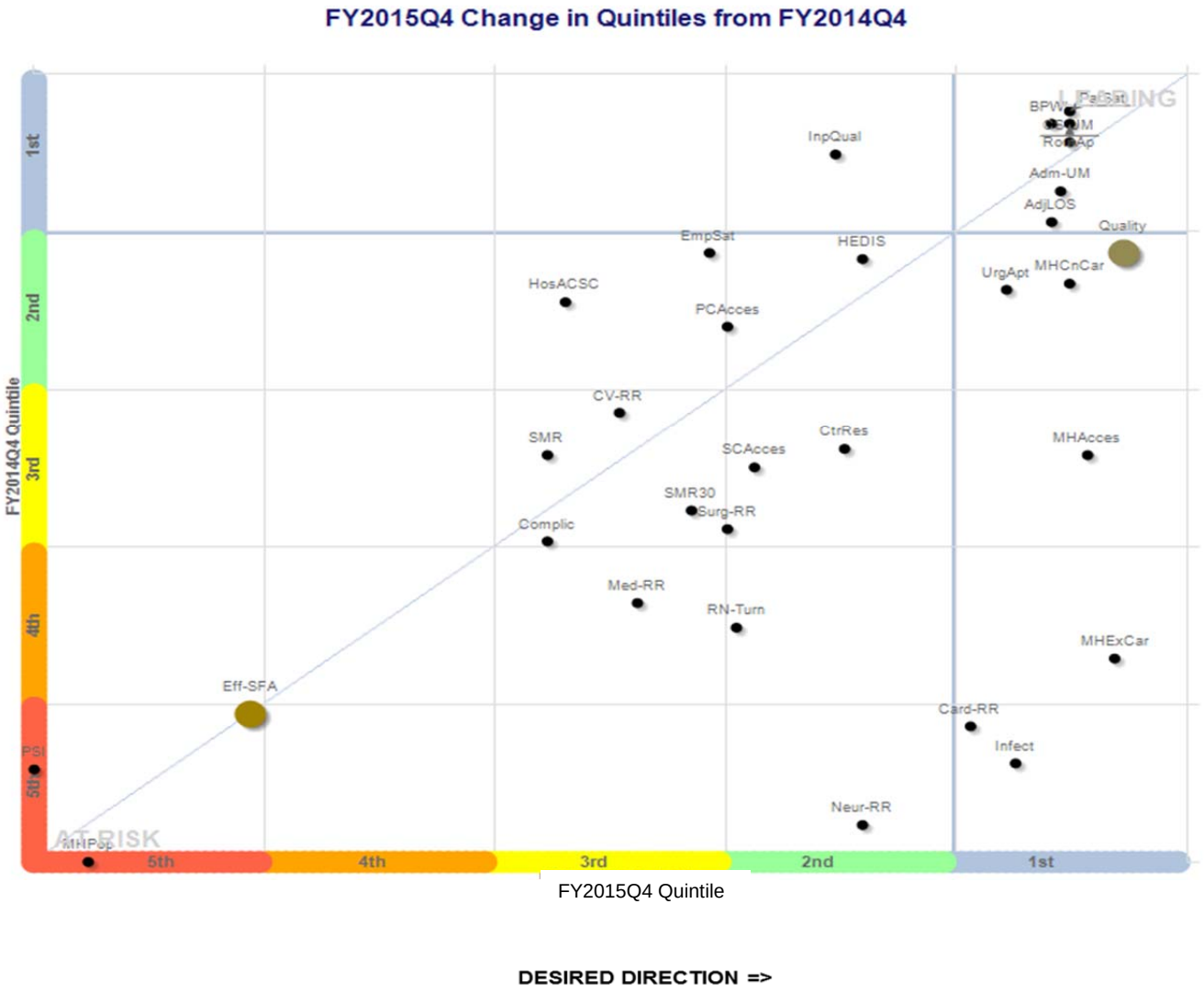
# Strategic Analytics for Improvement and Learning (SAIL)[2]




Marker color: Blue - 1st quintile; Green - 2nd; Yellow - 3rd; Orange - 4th; Red - 5th quintile.

[2] 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 |

**Appendix C**

# Acting Veterans Integrated Service Network Director Comments

**Department of Veterans Affairs**

# Memorandum

**Date:** 3/11/2016

**From:** Acting Director, VA Midwest Health Care Network (10N23)

**Subject:** **CAP Review of the Fargo VA Health Care System, Fargo, ND**

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

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

1. Thank you for conducting a comprehensive review at the Fargo VA Health Care System.

2. I have reviewed the document and concur with the response as submitted.

PATRICK J. KELLY, FACHE

# Facility Director Comments

**Department of Veterans Affairs**

# Memorandum

**Date:** 3/1/2016

**From:** Director, Fargo VA Health Care System (437/00)

**Subject:** **CAP Review of the Fargo VA Health Care System, Fargo, ND**

**To:** Director, VA Midwest Health Care Network (10N23)

1. The Fargo VA HCS concurs with all recommendations. Please see the attached actions plans for the recommendations identified from the recent review.

2. If you have any questions, please contact Ms. Joan Quick, Director, Quality, Safety & Value at (701) 239-3700 extension 3686.

Lavonne Liversage

LAVONNE LIVERSAGE, FACHE
Health Care System Director

# Comments to OIG's Report

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

**OIG Recommendations**

**Recommendation 1.** We recommended that facility managers ensure competency assessment for employees who prepare compounded sterile products includes gloved fingertip sampling.

Concur

Target date for completion: February 26, 2016

Facility response: The Pharmacy form for competency validation of Preparing Sterile Compounds was revised to include glove fingertip testing. All pharmacy employees who prepare CSP have successfully completed training and demonstrated competency. Competency will be reassessed on an annual basis. Compliance of staff competency will be presented at the Quality, Safety & Value Council annually.

**Recommendation 2.** We recommended that facility managers ensure all compounded sterile product labels contain the preparer and checker initials and the beyond use date.

Concur

Target date for completion: Completed

Facility response: Action taken at time of visit.

**Recommendation 3.** We recommended that physicians consistently document discharge progress notes or instructions that include all required elements and that facility managers monitor compliance.

Concur

Target date for completion: August 4, 2016

Facility response: The discharge note/instructions template was revised to include all required elements and was fully implemented on February 8, 2016. Monthly audits will be completed with the expectation that there be a 90% compliance rate for a minimum of 4 consecutive months. The audits will be reported monthly at the Quality, Safety and Value (QSV) Council starting April 26, 2016.

**Recommendation 4.** We recommended that employees ask inpatients whether they would like to discuss creating, changing, and/or revoking advance directives and that facility managers monitor compliance.

Concur

Target date for completion: August 4, 2016

Facility response: The Advanced Directive template was revised on 1/27/16 to include asking inpatient Veterans whether they would like to create, change, and/or revoke their Advance Directive. The Social Work Manager will perform monthly audits of the nursing admission assessment to ensure that inpatients are asked if they would like to create, change or revoke their Advanced Directives at time of admission, with the expectation that there be a 90% compliance rate for a minimum of 4 consecutive months. The audits will be reported monthly at the Quality, Safety and Value (QSV) Council starting April 26, 2016.

**Recommendation 5.** We recommended that the facility ensure new clinical employees complete suicide risk management training within the required timeframe and that facility managers monitor compliance.

Concur

Target date for completion: August 4, 2016

Facility response: Starting March 10, 2016, both the Suicide Risk Management training for Clinicians as well as the SAVE training for non-clinical staff will be completed during the new employee orientation time period. The TMS Coordinator will generate an automatic report to assess training compliance on a monthly basis; a copy will be sent to the Suicide Prevention Coordinator to ensure that ongoing oversite for monitoring and follow-up is conducted. The compliance expectation will be that 100% of staff will have completed the assigned training within the designated time frame. Monthly reports will be presented at Leadership – Morning Meeting and the Quality Council starting April 26, 2016.

**Recommendation 6.** We recommended that clinicians include documentation of assessment of available lethal means and how to keep the environment safe in Suicide Prevention Safety Plans and that facility managers monitor compliance.

Concur

Target date for completion: August 4, 2016

Facility response: On March 9, 2016 the Suicide Prevention Safety Plan template was revised to improve the assessment and documentation of available lethal means and how to keep the Veterans environment safe. Reducing access to lethal means – removing or locking firearms/medications was specifically added to this section. The Suicide Prevention Coordinator will conduct monthly audits for compliance. Audit results will be presented at the Quality, Safety and Value (QSV) Council.

# Office of Inspector General
# Contact and Staff Acknowledgments

| | |
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| **Contact** | For more information about this report, please contact the OIG at (202) 461-4720. |
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U.S. House of Representatives: Kevin Cramer, Kristi Noem, Rick Nolan, Collin C. Peterson

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

# Endnotes

[a] The references used for this topic were:
- VHA Directive 1026, *VHA Enterprise Framework for Quality, Safety, and Value*, August 2, 2013.
- VHA Directive 1117, *Utilization Management Program*, July 9, 2014.
- VHA Directive 2010-025, *Peer Review for Quality Management*, June 3, 2010.
- VHA Handbook 1050.01, *VHA National Patient Safety Improvement Handbook*, March 4, 2011.
- VHA Handbook 1100.19, *Credentialing and Privileging*, October 15, 2012.

[b] The references used for this topic included:
- VHA Directive 2005-037, *Planning for Fire Response*, September 2, 2005.
- VHA Directive 2009-026; *Location, Selection, Installation, Maintenance, and Testing of Emergency Eyewash and Shower Equipment*; May 13, 2009.
- Various requirements of The Joint Commission, the Occupational Safety and Health Administration, the International Association of Healthcare Central Service Materiel Management, the Health Insurance Portability and Accountability Act, National Fire Protection Association, Association of periOperative Registered Nurses, U.S. Pharmacopeial Convention, American National Standards Institute.

[c] The references used for this topic included:
- VHA Handbook 1108.06, *Inpatient Pharmacy Services*, June 27, 2006.
- VHA Handbook 1108.07, *Pharmacy General Requirements*, April 17, 2008.
- Various requirements of VA Pharmacy Benefits Management Services, The Joint Commission, the United States Pharmacopeial Convention, the American Society of Health-System Pharmacists, the Institute for Safe Medication Practices, the Food and Drug Administration, and the American National Standards Institute.

[d] The references used for this topic included:
- VHA Directive 1009, *Standards for Addressing the Needs of Patients Held in Temporary Bed Locations*, August 28, 2013.
- VHA Directive 1063, *Utilization of Physician Assistants (PA)*, December 24, 2013.
- VHA Handbook 1400.01, *Resident Supervision*, December 19, 2012.
- VHA Handbook 1907.01, *Health Information Management and Health Records*, March 19, 2015.

[e] The references used for this topic included:
- VHA Directive 1129, *Radiation Protection for Machine Sources of Ionizing Radiation*, February 5, 2015.
- VHA Handbook 1105.02, *Nuclear Medicine and Radiation Safety Service*, December 10, 2010.
- VHA Handbook 5005/77, *Staffing*, Part II, Appendix G25, Diagnostic Radiologic Technologist Qualifications Standard GS-647, June 26, 2014.
- The Joint Commission, "Radiation risks of diagnostic imaging," Sentinel Event Alert, Issue 47, August 24, 2011.
- VA Radiology, "Online Guide," updated October 4, 2011.
- The American College of Radiology, "ACR–AAPM TECHNICAL STANDARD FOR DIAGNOSTIC MEDICAL PHYSICS PERFORMANCE MONITORING OF COMPUTED TOMOGRAPHY (CT) EQUIPMENT, Revised 2012.

[f] The references used for this topic included:
- VHA Handbook 1004.02, *Advance Care Planning and Management of Advance Directives*, December 24, 2013.
- VHA Handbook 1907.01, *Health Information Management and Health Records*, July 22, 2014.

[g] The references used for this topic included:
- VHA Directive 2010-025, *Peer Review for Quality Management*, June 3, 2010.
- VHA Directive 2010-053, *Patient Record Flags*, December 3, 2010 (corrected 2/3/11).
- VHA Handbook 1050.01, *VHA National Patient Safety Improvement Handbook*, March 4, 2011.
- VHA Handbook 1160.01, *Uniform Mental Health Services in VA Medical Centers and Clinics*, September 11, 2008.
- VHA Handbook 1160.06, *Inpatient Health Services*, September 16, 2013.
- Various Deputy Under Secretary for Health for Operations and Management memorandums and guides.
- *VA Suicide Prevention Coordinator Manual*, August 2014.
- Various requirements of The Joint Commission.