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Clinical Assessment Program Review of the VA Salt Lake City Health Care System Salt Lake City, Utah

March 31, 2017

Washington, DC 20420

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Glossary

CAP	Clinical Assessment Program
CNH	community nursing home
EHR	electronic health record
EOC	environment of care
facility	VA Salt Lake City Health Care System
FY	fiscal year
MH	mental health
NA	not applicable
NM	not met
OIG	Office of Inspector General
PC	primary care
POCT	point-of-care testing
QSV	quality, safety, and value
RME	reusable medical equipment
SPS	Sterile Processing Service
VHA	Veterans Health Administration

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Executive Summary

Purpose and Objectives: The review provided a focused evaluation of the quality of care provided in the inpatient and outpatient settings of the VA Salt Lake City Health Care System. We reviewed clinical and administrative processes that affect patient care outcomes—Quality, Safety, and Value; Environment of Care; Medication Management; Coordination of Care; Diagnostic Care; Moderate Sedation; Community Nursing Home Oversight; and Management of Disruptive/Violent Behavior. We also followed up on recommendations from the previous Combined Assessment Program and Community Based Outpatient Clinic and Primary Care Clinic reviews and provided crime awareness briefings.

Results: We conducted the review during the week of December 5, 2016, and identified certain system weaknesses in credentialing and privileging and utilization management; general safety and reusable medical equipment processes and training; anticoagulation program processes and employee competency assessment; collection, reporting, and monitoring of patient transfer data; point-of-care testing; moderate sedation practices; community nursing home oversight; and disruptive or violent behavior management processes and training.

Review Impact: As a result of the findings, we could not gain reasonable assurance that:

1. The facility has an effective process for reviewing Ongoing Professional Practice Evaluation data.
2. Utilization management decisions are made with physician advisors' input.
3. The facility ensures a safe environment of care.
4. The facility has established effective processes and training for reusable medical equipment reprocessing.
5. Anticoagulation data is used to improve the quality of patient care.
6. Clinicians have documented competency to manage anticoagulation therapy patients.
7. Patient transfer data is used to improve the quality of patient care.
8. Clinicians appropriately manage critical point-of-care test values.
9. Required elements for the safe administration of moderate sedation are documented.
10. The facility monitors and assures the safe care of patients in the community nursing home program.
11. The facility effectively manages disruptive/violent behavior incidents and ensures employees receive training to reduce and prevent disruptive behaviors.

Recommendations: We made recommendations in all eight review areas.

Quality, Safety, and Value – Ensure that:
- Ongoing Professional Practice Evaluation data is reviewed semi-annually.
- Physician Utilization Management Advisors consistently document their decisions in the National Utilization Management Integration database.

Environment of Care – Ensure that:
- Environment of Care Committee meeting minutes consistently document discussions of environment of care rounds deficiencies, the specific deficiencies, corrective actions taken to address identified deficiencies, and resolutions.
- Fire drill attendance is documented, and fire drills have documented critiques.
- Eye protection equipment is readily available for employees.
- Standard operating procedures for the colonoscopes and endoscopes for esophagogastroduodenoscopy and endoscopic retrograde cholangiopancreatography procedures are consistent with manufacturer instructions for use.
- Sterile Processing Service employees receive training at orientation for the types of reusable medical equipment they reprocess.

Medication Management: Anticoagulation Therapy – Ensure that:
- All quality assurance data measures for the anticoagulation management program are reviewed and reported quarterly.
- Competency assessments for employees actively involved in the anticoagulation program include all required elements.

Coordination of Care: Inter-Facility Transfers – Ensure that:
- Data on patient transfers out of the facility are collected and reported.
- Patient transfers are monitored and evaluated as part of the quality management program.

Diagnostic Care: Point-of-Care Testing – Ensure that:
- The point-of-care testing procedure manual is readily available to employees.
- Employees who perform point-of-care glucose testing comply with facility policy for managing critical glucose values.

Moderate Sedation – Ensure that:
- The history and physical and/or pre-sedation assessment include history of previous adverse experience with sedation or anesthesia.
- Clinical teams performing moderate sedation procedures conduct and document timeouts prior to the procedures using a checklist.

Community Nursing Home Oversight – Ensure that:
- Social workers and registered nurses conduct and document cyclical clinical visits with the frequency required by Veterans Health Administration policy.

Management of Disruptive/Violent Behavior – Ensure that:

- The Patient Safety Manager and Patient Advocate consistently attend Disruptive Behavior Committee meetings.
- Clinicians inform patients about Patient Record Flags and the right to request to amend/appeal flag placement.
- Employees receive Level 1 Prevention and Management of Disruptive Behavior training and additional training as required for their assigned risk area within 90 days of hire and that the training is documented in employee training records.

Comments

The Veterans Integrated Service Network Director and Acting Facility Director agreed with the Clinical Assessment Program review findings and recommendations and provided acceptable improvement plans. (See Appendixes E and F, pages 40–48, for the full text of the Directors' comments.) We will follow up on the planned actions until they are completed.

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Purpose and Objectives

Purpose

This CAP review provided a focused evaluation of the quality of care provided in the inpatient and outpatient settings of the facility.

Objectives

CAP reviews are one element of OIG's efforts to ensure that our Nation's veterans receive high quality VA health care services. The reviews include cyclical evaluations of key clinical and administrative processes that affect patient care outcomes. Areas of focus include QSV, EOC, Medication Management, Coordination of Care, and Diagnostic Care.

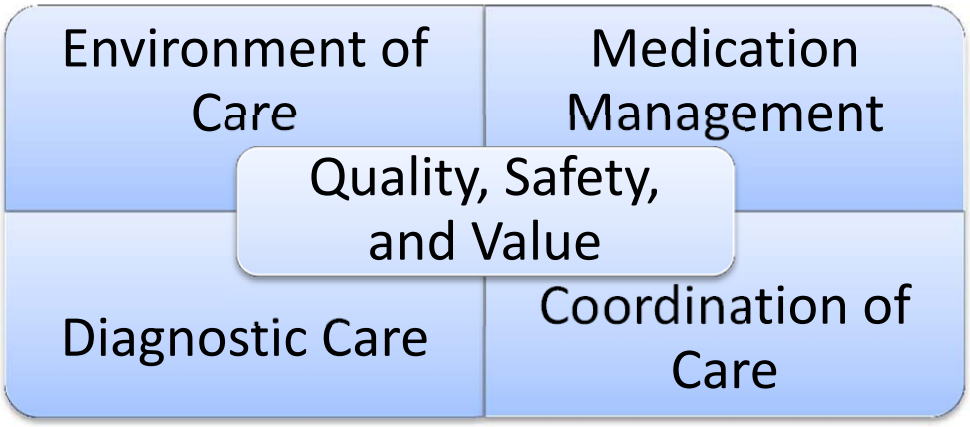
During this cycle, Moderate Sedation, CNH Oversight, and Management of Disruptive/Violent Behavior are processes that are high risk and problem-prone. We also followed up on recommendations from the previous Combined Assessment Program and Community Based Outpatient Clinic and PC Clinic reviews.

Additionally, OIG provides crime awareness briefings to increase employee understanding of the potential for program fraud and the requirement to refer suspected criminal activity to OIG.

Background

We evaluate key aspects of clinical care delivery in a variety of primary/specialty care and inpatient/outpatient settings. These aspects include QSV, EOC, Medication Management; Coordination of Care; and Diagnostic Care (see Figure 1 below).

Figure 1. Comprehensive Coverage of Continuum of Care



Source: VA OIG

Quality, Safety, and Value

According to the Institute of Medicine (now the National Academy of Medicine), there are six important components of a health care system that provides high quality care to individuals. The system:

1. Is safe (free from accidental injury) for all patients, in all processes, all the time.
2. Provides care that is effective (care that, wherever possible, is based on the use of systematically obtained evidence to make determinations regarding whether a preventive service, diagnostic test, therapy, or no intervention would produce the best outcome).
3. Is patient-centered. This concept includes respect for patients' values and preferences; coordination and integration of care; information, communication, and education; physical comfort; and involvement of family and friends.
4. Delivers care in a timely manner (without long waits that are wasteful and often anxiety-provoking).
5. Is efficient (uses resources to obtain the best value for the money spent).
6. Is equitable (bases care on an individual's needs and not on personal characteristics—such as gender, race, or insurance status—that are unrelated to the patient's condition or to the reason for seeking care).[1]

VA states that one of its strategies is to deliver high quality, veteran-centered care that compares favorably to the best of the private sector in measured outcomes, value, efficiency, and patient experience.[2]

Environment of Care

All facilities face risks in the environment, including those associated with safety and security, fire, hazardous materials and waste, medical equipment, and utility systems. The EOC is made up of three basic elements: (1) the building or space; (2) equipment used to support patient care; and (3) people, patients, and anyone else who enters the environment.[3]

The physical environment shapes every patient experience and all health care delivery, including those episodes of care that result in patient harm. Three patient safety areas are markedly influenced by the environment—health care-associated infections, medication safety, and falls. Because health care-associated infections are transmitted through air, water, and contact with contaminated surfaces, the physical environment plays a key role in preventing the spread of infections in health care settings. Medication safety is markedly influenced by physical environmental conditions, including light levels and workspace organization. Environmental features, such as the

[1] Teleki SS, Damberg, CL, Reville RT. *Quality of Health Care: What Is It, Why Is It Important, and How Can It Be Improved in California's Workers Compensation Programs?* Santa Monica: RAND Corporation; May 2003 Quality and Workers' Compensation Working Draft.
[2] Department of Veterans Affairs, Veterans Health Administration. *Blueprint for Excellence*. September 2014.
[3] The Joint Commission. *Comprehensive Accreditation Manual for Hospitals: E-dition*®: Joint Commission Resources; July 2016: Environment of Care (EC).

placement of doorways, flooring type, and the location of furniture, can contribute to patient falls and associated injuries.[4]

Medication Management

Comprehensive medication management is defined as the standard of care that ensures clinicians individually assess each patient's medications to determine that each is appropriate for the patient, effective for the medical condition, safe given the comorbidities and other medications prescribed, and able to be taken by the patient as intended. Medications are involved in 80 percent of all treatments and impact every aspect of a patient's life. Drug therapy problems occur every day. The Institute of Medicine (now the National Academy of Medicine) noted that while medications account for only 10 percent of total health care costs, their ability to control disease and impact overall costs, morbidity, and productivity—when appropriately used—is enormous. The components of the medication management process include procuring, storing, securing, prescribing or ordering, transcribing, preparing, dispensing, and administering.[5,6]

Coordination of Care

Coordination of care is the process of coordinating care, treatment, or services provided by a facility, including referring individuals to appropriate community resources to meet ongoing identified needs, implementing the plan of care, and avoiding unnecessary duplication of services. Coordination of care is recognized as a major challenge in the safe delivery of care. The rise of chronic illness means that a patient's care, treatment, and services likely will involve an array of providers in a variety of health care settings, including the patient's home.[7]

In a 2001 report entitled "Crossing the Quality Chasm: A New Health System for the 21st Century," the Institute of Medicine (now the National Academy of Medicine) noted that, "Because of the special vulnerability that accompanies illness or injury, coordination of care takes on special importance. Many patients depend on those who provide care to coordinate services whether tests, consultations, or procedures to ensure that accurate and timely information reaches those who need it at the appropriate time." Health care providers and organizations need to work together to coordinate their efforts to provide safe, quality care.[8]

[4] Joseph A, Malone EB. *The Physical Environment: An Often Unconsidered Patient Safety Tool*. Agency for Healthcare Research and Quality. Patient Safety Network; October 2012.
[5] Patient-Centered Primary Care Collaborative. *The Patient-Centered Medical Home: Integrating Comprehensive Medication Management to Optimize Patient Outcomes, Resource Guide*. 2nd ed; June 2012.
[6] The Joint Commission. *Comprehensive Accreditation Manual for Hospitals: E-dition*®: Joint Commission Resources; July 2016: Medication Management (MM).
[7] The Joint Commission. *Comprehensive Accreditation Manual for Hospitals: E-dition*®: Joint Commission Resources; July 2016: Provision of Care, Treatment, and Services (PC).
[8] Institute of Medicine. *Crossing the Quality Chasm: A New Health System for the 21st Century*. The National Academies Press; March 2001.

Diagnostic Care

The diagnostic process is a complex, patient-centered, collaborative activity that involves information gathering and clinical reasoning with the goal of determining a patient's health problem. Diagnostic testing may occur in successive rounds of information gathering, integration, and interpretation, with each round refining the working diagnosis. In many cases, diagnostic testing can identify a condition before it is clinically apparent; for example, an imaging study indicating the presence of coronary artery blockage can identify coronary artery disease even in the absence of symptoms. PC clinicians order laboratory tests in slightly less than one third of patient visits, and direct-to-patient testing is becoming increasingly prevalent.[9]

Medical imaging also plays a critical role in establishing the diagnoses for many conditions. The advancement of imaging technologies has improved the ability of clinicians to detect, diagnose, and treat conditions while also allowing patients to avoid more invasive procedures. Performed appropriately, diagnostic care facilitates the provision of timely, cost-effective, and high quality medical care.[10]

High-Risk and Problem-Prone Health Care Processes

Health care leaders must give priority to high-volume, high-risk, or problem-prone processes for performance improvement activities.[11] Specifically, they are responsible for identifying high-risk areas that could cause harm to patients, visitors, and employees; implementing programs to avert risks; and managing a robust reporting process for adverse events that do occur. But of all of their responsibilities, one of the most important is focusing on improving patient safety.[12]

Moderate sedation is a drug-induced depression of consciousness during which patients respond purposefully to verbal comments.[13] Properly credentialed providers and trained clinical staff must provide safe care while sedating patients for invasive procedures. Additionally, facility leaders must monitor moderate sedation adverse events, report and trend the use of reversal agents, and systematically aggregate and analyze the data to enhance patient safety and performance.[14]

[9] Committee on Diagnostic Error in Health Care. Balogh EP, Miller BT, Ball JR, eds. *Improving Diagnosis in Health Care*. Washington, DC: The National Academies Press; 2015: Chap. 2.
[10] Department of Veterans Affairs. Patient Care Services. Diagnostic Services. http://www.patientcare.va.gov/diagnosticservices.asp. Accessed September 21, 2016.
[11] The Joint Commission. *Comprehensive Accreditation Manual for Hospitals: E-dition*®: Joint Commission Resources; July 2016: Leadership (LD) Accreditation Requirements, LD.04.04.01, EP2.
[12] Bickmore, AM. Streamlining the Risk Management Process in Healthcare to Improve Workflow and Increase Patient Safety, *HealthCatalyst*, https://www.healthcatalyst.com/streamlining-risk-management-process-healthcare.
[13] American Society of Anesthesiologists (ASA), Practice Guidelines for Sedation and Analgesia by Non-Anesthesiologists, 2002. Anesthesiology 2002; 96:1004-17.
[14] VHA Directive 1073, *Moderate Sedation by Non-Anesthesiology Providers*, December 30, 2014.

As of October 2016, VHA has contracts with more than 1,800 CNHs where more than 9,500 veteran patients reside.[15] These CNHs may be within close proximity to a VA facility or located hundreds of miles away. VHA requires local oversight of CNHs, which includes monitoring and follow-up services for patients who choose to reside in nursing homes in the community. This involves annual reviews and monthly patient visits unless otherwise specified.[16]

According to the U.S. Bureau of Labor Statistics, health care workers are nearly five times more likely to be victims of nonfatal assaults or violent acts in their work places than average workers in all industries combined, and many of these assaults and violent acts are perpetrated by patients.[17] Management of disruptive/violent behavior is the process of reducing and preventing disruptive behaviors and other defined acts that threaten public safety through the development of policy, programs, and initiatives aimed at patient, visitor, and employee safety.[18] VHA has a directive that addresses the management of all individuals in VHA facilities whose behavior could jeopardize the health or safety of others, undermine a culture of safety in VHA, or otherwise interfere with the delivery of health care at a facility; however, staff training deadlines have been postponed several times.

Scope

To evaluate for compliance with requirements related to patient care quality, clinical functions, and the EOC, we physically inspected selected areas, discussed processes and validated findings with managers and employees, and reviewed clinical and administrative records. The review covered the following five aspects of clinical care.

- Quality, Safety, and Value
- Environment of Care
- Medication Management: Anticoagulation Therapy
- Coordination of Care: Inter-Facility Transfers
- Diagnostic Care: Point-of-Care Testing

[15] VA Corporate Data Warehouse. Accessed October 31, 2016.
[16] VHA Handbook 1143.2, *VHA Community Nursing Home Oversight Procedures*, June 4, 2004.
[17] U.S. Bureau of Labor Statistics. Janocha JA, Smith RT. *Workplace Safety and Health in the Health Care and Social Assistance Industry, 2003–07*. http://www.bls.gov/opub/mlr/cwc/workplace-safety-and-health-in-the-health-care-and-social-assistance-industry-2003-07.pdf. August 30, 2010. Accessed October 28, 2016.
[18] VHA Directive 2012-026, *Sexual Assaults and Other Defined Public Safety Incidents in Veterans Health Administration (VHA) Facilities*, September 27, 2012.

We also evaluated three additional review areas because of inherent risks and potential vulnerabilities.

- Moderate Sedation
- Community Nursing Home Oversight
- Management of Disruptive/Violent Behavior

We list the review criteria for each of the review areas in the topic checklists. Some of the items listed may not have been applicable because of a difference in size, function, or frequency of occurrence.

The review covered operations for FY 2015, FY 2016, and FY 2017 through December 5, 2016, and inspectors conducted the reviews 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 Combined Assessment Program report (*Combined Assessment Program Review of the VA Salt Lake City Health Care System, Salt Lake City, Utah,* Report No. 13-03655-84, February 25, 2014) and community based outpatient clinic report (*Community Based Outpatient Clinic and Primary Care Clinic Reviews at VA Salt Lake City Health Care System, Salt Lake City, Utah,* Report No. 13-03420-85, February 28, 2014).

On November 16, 2016, we presented crime awareness briefings for 95 employees. These briefings covered procedures for reporting suspected criminal activity to 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. We distributed an electronic survey to all facility employees and received 506 responses. We shared summarized results with facility managers.

In this report, we make recommendations for improvement. Recommendations pertain to issues that are significant enough for OIG to monitor until the facility implements corrective actions. Issues and concerns that come to our attention but are outside the scope of this CAP review will be considered for further review separate from the CAP process and may be referred accordingly.

Reported Accomplishment

Annual National Veterans Wheelchair Games

The facility, in partnership with the Paralyzed Veterans of America, hosted the 36th National Veterans Wheelchair Games June 27–July 2, 2016. The National Veterans Wheelchair Games is a rehabilitation and wheelchair sports program empowering veterans with spinal cord injuries, multiple sclerosis, amputations, and other neurological injuries to live more active and healthy lives through wheelchair sports and recreation.[19]

Each summer, veterans from across the United States and a team from Great Britain travel to a new community hosting the games. In 2016, approximately 537 veterans competed in 20 adaptive sporting events, and over 2,700 community volunteers contributed more than 28,000 volunteer hours.

The facility received great support from the local government and corporate community with in kind and financial support from organizations and entities such as Boeing, Salt Lake County, Utah Transit Authority, L-3 Communication Systems, the Larry H. and Gail Miller Family Foundation, University of Utah Health Care, the Utah Jazz, and the American United Federal Credit Union. The facility fostered very good working relationships with community adaptive sports and recreation partners, first responders and emergency preparedness organizations, the Utah National Guard, and Hill Air Force Base. The wheelchair games not only allowed the facility to showcase all available services for rehabilitation of injured veterans but also made it possible to develop new partnerships and strengthen relationships with many community partners to provide care and support to veterans.

[19] Utah Department of Veterans and Military Affairs. https://veterans.utah.gov/36th-annual-national-veterans-wheelchair-games/. Accessed December 19, 2016.

Results and Recommendations

Quality, Safety, and Value

The purpose of this review was to determine whether the facility complied with selected QSV program requirements.[a] VHA requires that its facilities operate a QSV program to monitor patient care quality and performance improvement activities. Many QSV activities are required by VHA directives, accreditation standards, and Federal regulations. Public Law 100-322 mandates VA's OIG to oversee VHA quality improvement programs at every level. This review focuses on the following program areas.

- Senior-level committee or group with responsibility for QSV/performance improvement
- Protected peer review
- Credentialing and privileging
- Utilization management
- Patient safety

We interviewed senior managers and key QSV employees, and we evaluated meeting minutes, 25 licensed independent practitioners' profiles, 10 protected peer reviews, 5 root cause analyses, 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.

Checklist 1. QSV Areas Reviewed, Findings, and 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. • The committee routinely reviewed aggregated data.		

NM	Areas Reviewed (continued)	Findings	Recommendations
X	Credentialing and privileging processes met selected requirements: • Facility policy/by-laws specified a frequency for clinical managers to review practitioners' Ongoing Professional Practice Evaluation data. • Facility clinical managers reviewed Ongoing Professional Practice Evaluation data at the frequency specified in the policy/by-laws. • The facility set triggers for when a Focused Professional Practice Evaluation for cause would be indicated.	• Seventeen profiles did not contain evidence that clinical managers reviewed Ongoing Professional Practice Evaluation data semi-annually.	**1.** We recommended that facility clinical managers consistently review Ongoing Professional Practice Evaluation data semi-annually and that facility managers monitor compliance.
	Protected peer reviews met selected requirements: • 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. • When the Peer Review Committee recommended individual improvement actions, clinical managers implemented the actions.		
X	Utilization management met selected requirements: • The facility completed at least 75 percent of all required inpatient reviews. • Physician Utilization Management Advisors documented their decisions in the National Utilization Management Integration database. • An interdisciplinary group reviewed utilization management data.	• For 57 of the 345 cases (17 percent) referred to Physician Utilization Management Advisors October 1, 2015–September 30, 2016, there was no evidence that advisors documented their decisions in the National Utilization Management Integration database. This resulted in less data for the facility to use to set benchmarks; identify trends, actions, and opportunities to improve efficiency; and monitor outcomes.	**2.** We recommended that Physician Utilization Management Advisors consistently document their decisions in the National Utilization Management Integration database and that facility managers monitor compliance.

NM	Areas Reviewed (continued)	Findings	Recommendations
	Patient safety met selected requirements: • The Patient Safety Manager entered all reported patient incidents into the WEBSPOT database. • The facility completed the required minimum of eight root cause analyses. • The facility provided feedback about the root cause analysis findings to the individual or department who reported the incident. • At the completion of FY 2016, the Patient Safety Manager submitted an annual patient safety report to facility leaders.		
	Overall, if QSV reviews identified significant issues, the facility took actions and evaluated them for effectiveness.		
	Overall, senior managers actively participated in QSV activities.		

Environment of Care

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 SPS and the hemodialysis unit.[b]

VHA must manage risks in the environment in order to promote a safe, functional, and supportive environment. Further, VHA must establish systematic infection prevention and control program to reduce the possibility of acquiring and transmitting infections. We selected the hemodialysis unit and SPS as special emphasis areas due to the increased potential for exposure to infectious agents inherent to hemodialysis and procedures using RME. Hemodialysis patients are at higher risk for infections for various reasons, including that hemodialysis requires vascular access for prolonged periods of time and that opportunities exist for transmission of infectious agents when multiple patients receive dialysis concurrently. RME is intended for repeated use on different patients after being reprocessed through cleaning, disinfection, and/or sterilization. Patients undergoing procedures using RME are at higher risk of exposure to infectious agents if RME is not properly reprocessed.

We inspected the surgical intensive care, medical/surgical (3 West and 2 East), inpatient MH, and hemodialysis units; the Emergency Department; SPS; the gastroenterology laboratory; and the Ely community based outpatient clinic. Additionally, we reviewed relevant documents and 15 employee training records, and we interviewed 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.

Checklist 2. EOC Areas Reviewed, Findings, and Recommendations

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.	Five months of EOC Committee meeting minutes reviewed did not include consistent discussion of EOC rounds deficiencies, the specific deficiencies, corrective actions taken to address the deficiencies, and resolutions.	**3.** We recommended that Environment of Care Committee meeting minutes consistently document discussion of environment of care rounds deficiencies, the specific deficiencies, corrective actions taken to address identified deficiencies, and resolutions.
	The facility conducted an infection prevention risk assessment.		

NM	Areas Reviewed for General EOC (continued)	Findings	Recommendations
	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 procedure for cleaning equipment between patients.		
X	The facility conducted required fire drills in buildings designated for health care occupancy and documented drill critiques.	Facility managers did not document attendance for 15 of 48 drills (31 percent), and fire drills did not have documented critiques.	**4.** We recommended that facility managers ensure attendance is documented for all fire drills. **5.** We recommended that facility managers ensure fire drills have documented critiques.
	The facility had a policy/procedure/guideline for identification of individuals entering the facility, and units/areas complied with requirements.		
X	The facility met general safety requirements.	• In two of seven patient care areas, eye protection equipment was not readily available.	**6.** We recommended that facility managers ensure eye protection equipment is readily available for employees.
	The facility met environmental cleanliness requirements.		
	Areas Reviewed for SPS		
	The facility had a policy for cleaning, disinfecting, and sterilizing RME.		
X	The facility's standard operating procedures for selected RME were current and consistent with the manufacturers' instructions for use.	• Standard operating procedures for the colonoscopes and endoscopes for esophagogastroduodenoscopy and endoscopic retrograde cholangiopancreatography were not consistent with manufacturer instructions for use.	**7.** We recommended that facility managers ensure standard operating procedures for the colonoscopes and endoscopes for esophagogastroduodenoscopy and endoscopic retrograde cholangiopancreatography are consistent with manufacturer instructions for use.

NM	Areas Reviewed for SPS (continued)	Findings	Recommendations
	The facility performed quality control testing on selected RME with the frequency required by local policy and took appropriate action on positive results.		
X	Selected SPS employees had evidence of the following for selected RME: • Training and competencies at orientation if employed less than or equal to 1 year • Competencies within the past 12 months or with the frequency required by local policy if employed more than 1 year	• Neither of two applicable employees had documentation of training at orientation for selected RME.	**8.** We recommended that Sterile Processing Service managers ensure Sterile Processing Service employees receive training at orientation for the types of reusable medical equipment they reprocess.
	The facility met infection prevention requirements in SPS areas.		
	Standard operating procedures for selected RME were located in the area where reprocessing occurred.		
	SPS employees checked eyewash stations in SPS areas weekly.		
	SPS employees had access to Safety Data Sheets in areas where they used hazardous chemicals.		
	Areas Reviewed for the Hemodialysis Unit		
	The facility had a policy or procedure for preventive maintenance of hemodialysis machines and performed maintenance at the frequency required by local policy.		
	Selected hemodialysis unit employees had evidence of bloodborne pathogens training within the past 12 months.		
	The facility met environmental safety requirements on the hemodialysis unit.		
	The facility met infection prevention requirements on the hemodialysis unit.		

NM	Areas Reviewed for the Hemodialysis Unit (continued)	Findings	Recommendations
	The facility met medication safety and security requirements on the hemodialysis unit.		
	The facility met privacy requirements on the hemodialysis unit.		

Medication Management: Anticoagulation Therapy

The purpose of this review was to determine whether facility clinicians appropriately managed and provided education to patients with new orders for anticoagulant medication.[c] During FY 2016, more than 482,000 veterans received an anticoagulant. Anticoagulants (commonly called blood thinners) are a class of drugs that work to prevent the coagulation or clotting of blood. For this review, we evaluated warfarin (Coumadin®) and direct-acting oral anticoagulants. Clinicians use anticoagulants for both the treatment and prevention of cardiac disease, cerebrovascular accident (stroke), and thromboembolism[20] in both the inpatient and outpatient setting. Although these medications offer substantial benefits, their use or misuse carries a significant potential for patient harm. A dose less than the required amount for therapeutic effect can increase the risk of thromboembolic complications while a dose administered at levels greater than required for treatment can increase the risk of bleeding complications. The Joint Commission's National Patient Safety Goal 3.05.01 focuses on improving anticoagulation safety to reduce patient harm and states, "…anticoagulation medications are more likely than others to cause harm due to complex dosing, insufficient monitoring, and inconsistent patient compliance."

We reviewed relevant documents and the competency assessment records of 10 employees actively involved in the anticoagulant program, and we interviewed key employees. Additionally, we reviewed the EHRs of 39 randomly selected patients who were prescribed new anticoagulant medications July 1, 2015 through June 30, 2016. The table below shows the areas reviewed for this topic. The areas marked as NM did not meet applicable requirements and needed improvement.

Checklist 3. Medication Management: Anticoagulation Therapy Areas Reviewed, Findings, and Recommendations

NM	Areas Reviewed	Findings	Recommendations
	The facility had policies and processes for anticoagulation management that included required content.		
	The facility used algorithms, protocols or standardized care processes for the: • Initiation and maintenance of warfarin • Management of anticoagulants before, during, and after procedures • Use of weight-based, unfractionated heparin		

[20] Thromboembolism is the obstruction of a blood vessel by a blood clot that has become dislodged from another site in the circulation.

NM	Areas Reviewed (continued)	Findings	Recommendations
	The facility provided patients with a direct telephone number for anticoagulation-related calls during normal business hours and defined a process for patient anticoagulation-related calls outside normal business hours.		
	The facility designated a physician as the anticoagulation program champion.		
	The facility defined ways to minimize the risk of incorrect tablet strength dosing errors.		
X	The facility routinely reviewed quality assurance data for the anticoagulation management program at the facility's required frequency at an appropriate committee.	• The facility did not consistently review and report all five quality assurance data measures for the anticoagulation management program quarterly.	**9.** We recommended that the facility consistently review and report all quality assurance data measures for the anticoagulation management program quarterly and that facility managers monitor compliance.
	For inpatients with newly prescribed anticoagulant medications, clinicians provided transition follow-up and education specific to the new anticoagulant.		
	Clinicians obtained required laboratory tests: • Prior to initiating anticoagulant medications • During anticoagulation treatment at the frequency required by local policy		
	When laboratory values did not meet selected criteria, clinicians documented a justification/rationale for prescribing the anticoagulant.		

NM	Areas Reviewed (continued)	Findings	Recommendations
X	The facility required competency assessments for employees actively involved in the anticoagulant program, and clinical managers completed competency assessments that included required content at the frequency required by local policy.	• For the five pharmacy employees actively involved in the anticoagulant program, competency assessments did not include: o Nutrient interactions associated with anticoagulation therapy o Drug to drug interactions associated with anticoagulation therapy • For the five nursing employees actively involved in the anticoagulant program, competency assessments did not include: o Knowledge of standard terminology o Pharmacology of anticoagulants o Monitoring requirements o Dose calculation o Common side effects o Nutrient interactions associated with anticoagulation therapy o Drug to drug interactions associated with anticoagulation therapy	**10.** We recommended that for employees actively involved in the anticoagulant program, clinical managers include in competency assessments knowledge of standard terminology, pharmacology of anticoagulants, monitoring requirements, dose calculation, common side effects, nutrient interactions associated with anticoagulation therapy, and drug to drug interactions associated with anticoagulation therapy and that facility managers monitor compliance.

Coordination of Care: Inter-Facility Transfers

The purpose of this review was to evaluate selected aspects of the facility's patient transfer process, specifically transfers out of the facility.[d] Inter-facility transfers are frequently necessary to provide patients with access to specific providers or services. The movement of an acutely ill person from one institution to another exposes the patient to risks, while in some cases, failing to transfer a patient may be equally risky. VHA has the responsibility to ensure that transfers into and out of its medical facilities are carried out appropriately under circumstances that provide maximum safety for patients and comply with applicable standards.

We reviewed relevant documents and interviewed key employees. Additionally, we reviewed the EHRs of 49 randomly selected patients who were transferred acutely out of facility inpatient beds or the Emergency Department/urgent care center to another VHA facility or non-VA facility July 1, 2015 through June 30, 2016. The table below shows the areas reviewed for this topic. The areas marked as NM did not meet applicable requirements and needed improvement.

Checklist 4. Coordination of Care: Inter-Facility Transfers Areas Reviewed, Findings, and Recommendations

NM	Areas Reviewed	Findings	Recommendations
	The facility had a policy that addressed patient transfers and included required content.		
X	The facility collected and reported data about transfers out of the facility.	• There was no evidence the facility collected and reported data about transfers out of the facility.	**11.** We recommended that the facility collect and report data on patient transfers out of the facility.
	Transferring providers completed VA Form 10-2649A and/or transfer/progress notes prior to or within a few hours after the transfer that included the following elements: • Date of transfer • Documentation of patient or surrogate informed consent • Medical and/or behavioral stability • Identification of transferring and receiving provider or designee • Details of the reason for transfer or proposed level of care needed		

NM	Areas Reviewed (continued)	Findings	Recommendations
	When staff/attending physicians did not write transfer notes, acceptable designees: • Obtained and documented staff/attending physician approval • Obtained staff/attending physician countersignature on the transfer note		
	When the facility transferred patients out, sending nurses documented transfer assessments/notes.		
	In emergent transfers, providers documented: • Patient stability for transfer • Provision of all medical care within the facility's capacity		
	Communication with the accepting facility or documentation sent included: • Available history • Observations, signs, symptoms, and preliminary diagnoses • Results of diagnostic studies and tests		
X	The facility monitored and evaluated transfers as part of the quality management program.	• There was no evidence that employees integrated patient transfers into the facility's quality management program.	**12.** We recommended that the facility monitor and evaluate patient transfers as part of the quality management program.

Diagnostic Care: Point-of-Care Testing

The purpose of this review was to evaluate the facility's glucometer POCT program compliance with applicable laboratory regulatory standards and quality testing practices as required by VHA, the College of American Pathologists, and The Joint Commission.[e] The majority of laboratory testing is performed in the main laboratory. However, with newer technologies, testing has emerged from the laboratory to the patient's bedside, the patient's home, and other non-laboratory sites. This is called POCT (also known as ancillary or waived testing) and can include tests for blood glucose, fecal occult blood, hemoglobin, and prothrombin time.

All laboratory testing performed in VHA facilities must adhere to quality testing practices. These practices include annual competency assessment and quality control testing. Failure to implement and comply with regulatory standards and quality testing practices can jeopardize patient safety and place VHA facilities at risk. Erroneous results can lead to inaccurate diagnoses, inappropriate medical treatment, and poor patient outcomes.[21]

We reviewed relevant documents, the EHRs of 49 randomly selected inpatients and outpatients who underwent POCT for blood glucose July 1, 2015 through June 30, 2016, and the annual competency assessments of 36 clinicians who performed the glucose testing. Additionally, we interviewed key employees and conducted onsite glucometer inspections of the surgical intensive care, medical/surgical (2 East), inpatient MH, and hemodialysis units; the Nuclear Medicine Service; the Substance Abuse Residential Rehabilitation Treatment Program; the Emergency Department; the dental clinic; and the gastroenterology laboratory to assess compliance with manufacturers' maintenance and solution/reagent storage requirements. The table below shows the areas reviewed for this topic. The areas marked as NM did not meet applicable requirements and needed improvement.

Checklist 5. Diagnostic Care: POCT Areas Reviewed, Findings, and Recommendations

NM	Areas Reviewed	Findings	Recommendations
	The facility had a policy delineating requirements for the POCT program and required oversight by the Chief of Pathology and Laboratory Medicine Service.		
	The facility had a designated POCT/Ancillary Testing Coordinator.		
	The Chief of Pathology and Laboratory Medicine Service approved all tests performed outside the main laboratory.		

[21] The Joint Commission. *Comprehensive Accreditation Manual for Laboratories and Point-of-Care Testing*. Update 2. September 2010.

NM	Areas Reviewed (continued)	Findings	Recommendations
	The facility had a process to ensure employee competency for POCT with glucometers and evaluated competencies at least annually.		
	The facility required documentation of POCT results in the EHR.		
	A regulatory agency accredited the facility's POCT program.		
	Clinicians documented test results in the EHR.		
	Clinicians initiated appropriate clinical action and follow up for test results.		
X	The facility had POCT procedure manuals readily available to employees.	• The POCT procedure manual was not available to employees in five of nine areas inspected.	**13.** We recommended that the Chief of Pathology and Laboratory Medicine Service ensure the point-of-care testing procedure manual is readily available to employees.
	Quality control testing solutions/reagents and glucose test strips were current (not expired).		
	The facility managed and performed quality control in accordance with its policy/standard operating procedure and manufacturer's recommendations.		
	Glucometers were clean.		
X	POCT employees complied with facility policy requirements to follow established procedures for managing critical values by repeating the test, notifying the responsible clinician, and documenting action taken.	• The facility reported that for 42 of the 174 critical glucose values (24 percent) July 1 through November 30, 2016, employees did not consistently follow facility policy for managing critical results.	**14.** We recommended that the Chief of Pathology and Laboratory Medicine Service ensure employees who perform point-of-care glucose testing comply with facility policy for managing critical glucose values.

Moderate Sedation

The purpose of this review was to evaluate selected aspects of care to determine whether the facility complied with applicable policies in the provision of moderate sedation.[f] During calendar year 2016, VHA clinicians performed more than 600,000 moderate sedation procedures of which more than half were gastroenterology-related endoscopies.[22] Moderate sedation is a drug-induced depression of consciousness during which patients are able to respond to verbal commands. Non-anesthesiologists administer sedatives and analgesics to relieve anxiety and increase patient comfort during invasive procedures and usually do not have to provide interventions to maintain a patent airway, spontaneous ventilations, or cardiovascular function.[23] However, serious adverse events can occur, including cardiac and respiratory depression, brain damage due to low oxygen levels, cardiac arrest, or death. To minimize risks, VHA and The Joint Commission have issued requirements and standards for moderate sedation care.

We reviewed relevant documents, interviewed key employees, and inspected the cardiac catheterization, gastroenterology, interventional radiology, Emergency Department, and dental procedure rooms/areas to assess whether required equipment and sedation medications were available. Additionally, we reviewed the EHRs of 38 randomly selected patients who underwent an invasive procedure involving moderate sedation July 1, 2015 through June 30, 2016, and the training records of 15 clinical employees who performed or assisted during these procedures. The table below shows the areas reviewed for this topic. The areas marked as NM did not meet applicable requirements and needed improvement.

Checklist 6. Moderate Sedation Areas Reviewed, Findings, and Recommendations

NM	Areas Reviewed	Findings	Recommendations
	The facility reported and trended the use of reversal agents in moderate sedation cases, processed adverse events/complications in a similar manner as operating room anesthesia adverse events, and noted the absence of adverse events in Moderate Sedation Committee reports.		

[22] Per VA Corporate Data Warehouse data pull on February 22, 2017.
[23] American Society of Anesthesiologists. Practice Guidelines for Sedation and Analgesia by Non-Anesthesiologists. *Anesthesiology*. 2002; 96:1004.

NM	Areas Reviewed (continued)	Findings	Recommendations
X	Providers performed history and physical examinations within 30 calendar days prior to the moderate sedation procedure, and the history and physical and the pre-sedation assessment in combination included required elements.	• In nine EHRs (24 percent), providers did not include history of previous adverse experience with sedation or anesthesia in the history and physical and pre-sedation assessment.	**15.** We recommended that providers include history of previous adverse experience with sedation or anesthesia in the history and physical and/or pre-sedation assessment and that facility managers monitor compliance.
	Providers re-evaluated patients immediately before moderate sedation for changes since the prior assessment.		
	Providers documented informed consent prior to moderate sedation procedures, and the name of provider listed on the consent was the same as the provider who performed the procedure, or the patient was notified of the change.		
X	The clinical team, including the provider performing the procedure, conducted and documented a timeout prior to the moderate sedation procedure.	• In four EHRs (11 percent), there was no evidence that the clinical team and the provider who performed the moderate sedation procedure conducted a timeout and/or documented the timeout using a checklist.	**16.** We recommended that clinical teams, including the providers performing the procedures, conduct and document timeouts using a checklist prior to moderate sedation procedures and that facility managers monitor compliance.
	Post-procedure documentation included assessments of patient mental status and pain level.		
	Clinical employees discharged patients from the recovery area with orders from the provider who performed the procedure or according to criteria approved by moderate sedation clinical leaders.		
	Clinical employees discharged moderate sedation patients in the company of a responsible adult.		
	Selected clinical employees had current training for moderate sedation.		

NM	Areas Reviewed (continued)	Findings	Recommendations
	The clinical team kept monitoring and resuscitation equipment and reversal agents in the general areas where moderate sedation was administered.		
	To minimize risk, clinical employees did not store anesthetic agents in procedure rooms/areas where only moderate sedation procedures were performed by licensed independent practitioners who do not have the training and ability to rescue a patient from general anesthesia.		

Community Nursing Home Oversight

The purpose of this review was to assess whether the facility complied with applicable requirements regarding the monitoring of veterans in contracted CNHs.[g] Since 1965, VHA has provided nursing home care under contracts. VHA facilities must integrate the CNH program into their Quality Improvement Programs. The Facility Director establishes the CNH Oversight Committee, which reports to the chief clinical officer (Chief of Staff, Associate Director for Patient Care Services, or the equivalent) and includes multidisciplinary management-level representatives from social work, nursing, quality management, acquisition, and the medical staff. The CNH Oversight Committee must meet at least quarterly.[24] Local oversight of CNHs is achieved through annual reviews and monthly visits.

We reviewed relevant documents, the EHRs of 39 randomly selected patients who received CNH care for more than 3 months during the timeframe July 1, 2015 through June 30, 2016, and the results from CNH annual reviews completed July 5, 2015 through June 30, 2016. Additionally, we interviewed key employees. The table below shows the areas reviewed for this topic. The area marked as NM did not meet applicable requirements and needed improvement.

Checklist 7. CNH Oversight Areas Reviewed, Findings, and Recommendations

NM	Areas Reviewed	Findings	Recommendations
	The facility had a CNH Oversight Committee that met at least quarterly and included representation by the required disciplines.		
	The facility integrated the CNH Program into its Quality Improvement Program.		
	The facility documented a hand-off for patients placed in CNHs outside of its catchment area.		
	The CNH Review Team completed CNH annual reviews.		
	When CNH annual reviews noted four or more exclusionary criteria, facility managers completed exclusion review documentation.		

[24] VHA Handbook 1143.2, *VHA Community Nursing Home Oversight Procedures*, June 4, 2004.

NM	Areas Reviewed (continued)	Findings	Recommendations
X	Social workers and registered nurses documented clinical visits that alternated on a cyclical basis.	• Thirty EHRs (77 percent) did not contain documentation of social worker and registered nurse cyclical clinical visits with the frequency required by VHA policy. At least 2 of these 30 patients resided in each of the eight CNHs in our review.	**17.** We recommended that facility managers ensure social workers and registered nurses conduct and document cyclical clinical visits with the frequency required by Veterans Health Administration policy and monitor compliance.

Management of Disruptive/Violent Behavior

The purpose of this review was to determine the extent to which the facility complied with selected requirements in the management of disruptive and violent behavior.[h] VHA policy states a commitment to reducing and preventing disruptive behaviors and other defined acts that threaten public safety through the development of policy, programs, and initiatives aimed at patient, visitor, and employee safety. In addition, Public Law 112-154, section 106 directed VA to develop and implement a comprehensive policy on the reporting and tracking of public safety incidents that occur at each medical facility.

We reviewed relevant documents, the EHRs of 50 randomly selected patients who exhibited disruptive or violent behavior, 2 Reports of Contact from violent/disruptive patient/employee/other (visitor) incidents that occurred during the 12-month period July 1, 2015 through June 30, 2016, and the training records of 26 recently hired employees who worked in areas at low, moderate, or high risk for violence. Additionally, we interviewed key employees. The table below shows the areas reviewed for this topic. The areas marked as NM did not meet applicable requirements and needed improvement.

Checklist 8. Management of Disruptive/Violent Behavior Areas Reviewed, Findings, and Recommendations

NM	Areas Reviewed	Findings	Recommendations
	The facility had a policy, procedure, or guideline on preventing and managing disruptive or violent behavior.		
	The facility conducted an annual Workplace Behavioral Risk Assessment.		
X	The facility had implemented: • An Employee Threat Assessment Team or acceptable alternate group • A Disruptive Behavior Committee/Board with appropriate membership • A disruptive behavior reporting and tracking system	• The Patient Safety Manager and the Patient Advocate did not consistently attend Disruptive Behavior Committee meetings.	**18.** We recommended that the Patient Safety Manager and Patient Advocate consistently attend Disruptive Behavior Committee meetings.
	The facility collected and analyzed disruptive or violent behavior incidents data.		
	The facility assessed physical security and included and tested equipment in accordance with the local physical security assessment.		

NM	Areas Reviewed (continued)	Findings	Recommendations
X	Clinical managers reviewed patients' disruptive or violent behavior and took appropriate actions, including: • Ensuring discussion by the Disruptive Behavior Committee/Board and entry of a progress note by a clinician committee/board member • Informing patients about Patient Record Flag placement and the right to request to amend/appeal the flag placement • Ensuring Chief of Staff or designee approval of an Order of Behavioral Restriction	• In 21 of the 22 applicable EHRs, there was no evidence that clinicians informed the patients about the Patient Record Flags and/or the right to request to amend/appeal Patient Record Flag placement.	**19.** We recommended that facility clinical managers ensure clinicians inform patients about the Patient Record Flags and the right to request to amend/appeal Patient Record Flag placement.
	When a Patient Record Flag was placed for an incident of disruptive behavior in the past, a clinician reviewed the continuing need for the flag within the past 2 years.		
	The facility managed selected non-patient related disruptive or violent incidents appropriately according to VHA and local policy.		
X	The facility had a security training plan for employees at all risk levels. • All employees received Level 1 training within 90 days of hire. • All employees received additional training as required for the assigned risk area within 90 days of hire.	• Ten of the 26 employee training records did not contain documentation of Level 1 training within 90 days of hire. • Fifteen of the 26 employee training records did not contain documentation of the training required for their assigned risk area within 90 days of hire.	**20.** We recommended that facility managers ensure all employees receive Level 1 Prevention and Management of Disruptive Behavior training and additional training as required for their assigned risk area within 90 days of hire and that the training is documented in employee training records.

Facility Profile

Table 1 below provides general background information for this facility.

Table 1. Facility Profile for Salt Lake City (660) for FY 2016

Profile Element	Facility Data
Veterans Integrated Service Network Number	19
Complexity Level	1a-High complexity
Affiliated/Non-Affiliated	Affiliated
Total Medical Care Budget in Millions	$482.9
Number of:	
• **Unique Patients**	57,266
• **Outpatient Visits**	685,269
• **Unique Employees**[25]	2,080
Type and Number of Operating Beds:	
• **Acute**	85
• **MH**	30
• **Community Living Center**	NA
• **Domiciliary**	15
Average Daily Census:	
• **Acute**	66
• **MH**	18
• **Community Living Center**	NA
• **Domiciliary**	13

Source: VA Office of Academic Affiliations, VHA Support Service Center, and VA Corporate Data Warehouse

Note: We did not assess VA's data for accuracy or completeness.

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

VA Outpatient Clinic Profiles[26]

The VA outpatient clinics in the communities within the catchment area of the facility provide PC integrated with women's health, MH, and telehealth services. Some also provide specialty care, diagnostic, and ancillary services. Table 2 below provides information relative to each of the clinics.

Table 2. VA Outpatient Clinic Workload/Encounters[27] and Specialty Care, Diagnostic, and Ancillary Services Provided for FY 2016

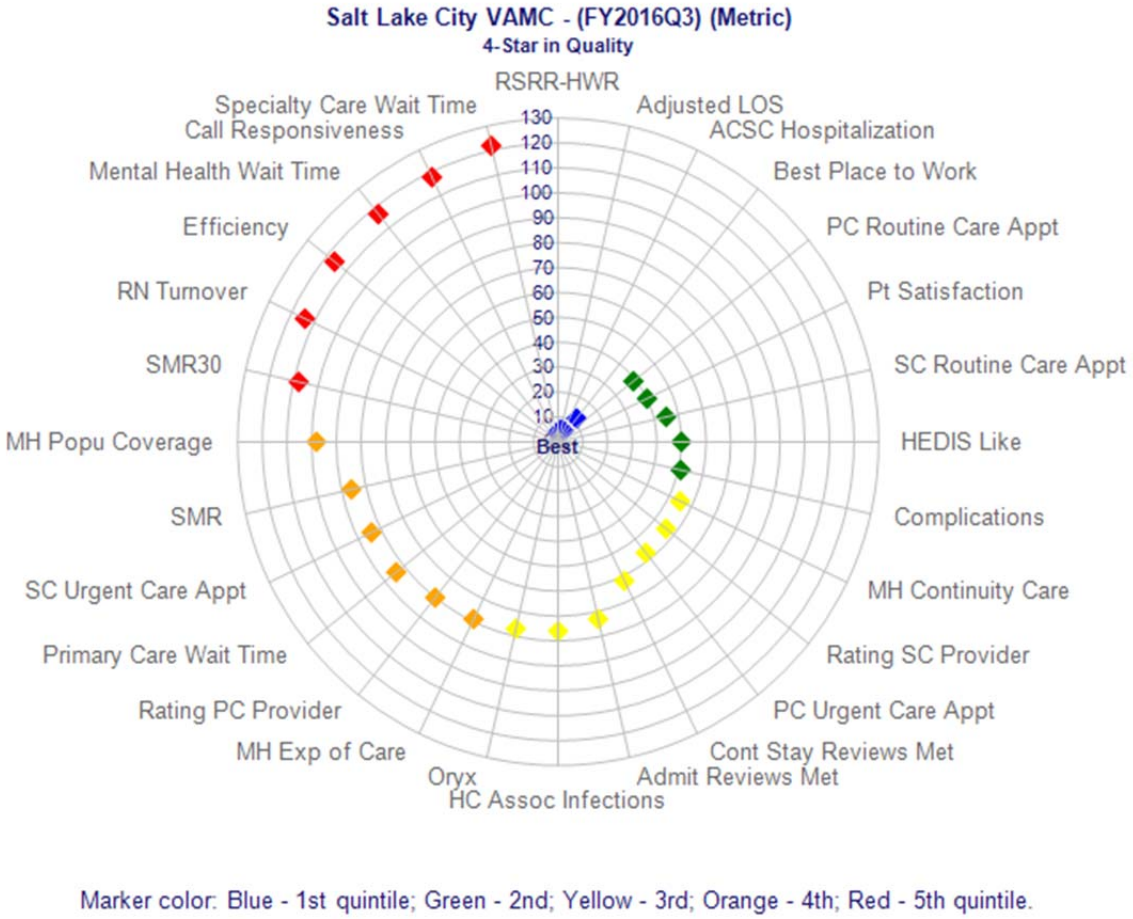
Location	Station No.	PC Workload/ Encounters	MH Workload/ Encounters	Specialty Care Services[28] Provided	Diagnostic Services[29] Provided	Ancillary Services[30] Provided
Pocatello, ID	660GA	10,373	4,252	Cardiology Dermatology Eye	EKG Laboratory & Pathology	Nutrition Pharmacy Weight Management
South Ogden, UT	660GB	9,870	5,068	Cardiology Dermatology Endocrinology Eye	EKG Laboratory & Pathology	Nutrition Pharmacy Weight Management
Ely, NV	660GC	1,099	NA	NA	Laboratory & Pathology	NA
Roosevelt, UT	660GD	1,619	196	Cardiology	Laboratory & Pathology	Social Work
Orem, UT	660GE	5,359	3,362	Cardiology Endocrinology Eye	EKG Laboratory & Pathology	Nutrition Pharmacy Weight Management
St. George, UT	660GG	6,359	1,220	Cardiology Dermatology Eye Orthopedics	EKG Laboratory & Pathology	Nutrition Pharmacy Weight Management
West Valley City, UT	660GJ	11,921	1,899	Dermatology Endocrinology Eye	EKG	Nutrition Pharmacy Social Work Weight Management
Elko, NV	660GK	1,213	184	Cardiology Endocrinology Eye	EKG Laboratory & Pathology	Nutrition

Source: *VHA Support Service Center and VA Corporate Data Warehouse*

Note: We did not assess VA's data for accuracy or completeness.

[26] Includes all outpatient clinics in the community that were in operation before February 15, 2016. We have omitted Idaho Falls, ID (660QA) and Price, UT (660QB), as no workload/encounters or services were reported.
[27] An encounter is a professional contact between a patient and a practitioner vested with responsibility for diagnosing, evaluating, and treating the patient's condition.
[28] Specialty care services refer to non-PC and non-MH services provided by a physician.
[29] Diagnostic services include EKG, EMG, laboratory, nuclear medicine, radiology, and vascular lab services.
[30] Ancillary services include chiropractic, dental, nutrition, pharmacy, prosthetic, social work, and weight management services.

Strategic Analytics for Improvement and Learning (SAIL)[31]

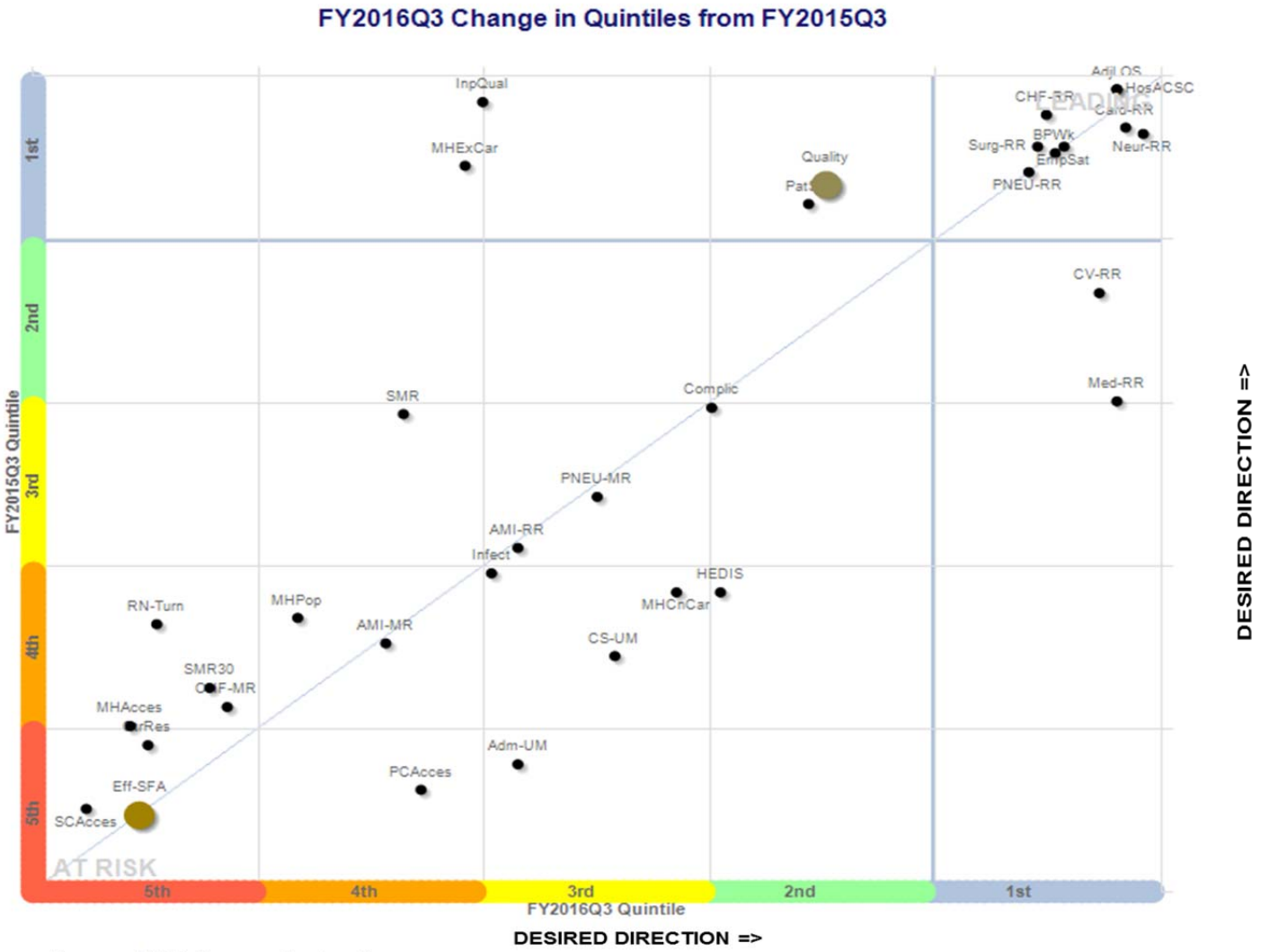


Source: VHA Support Service Center

Note: We did not assess VA's data for accuracy or completeness.

[31] Metric definitions follow the graphs.

Scatter Chart



NOTE

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

Source: VHA Support Service Center

Note: We did not assess VA's data for accuracy or completeness.

Metric Definitions[i]

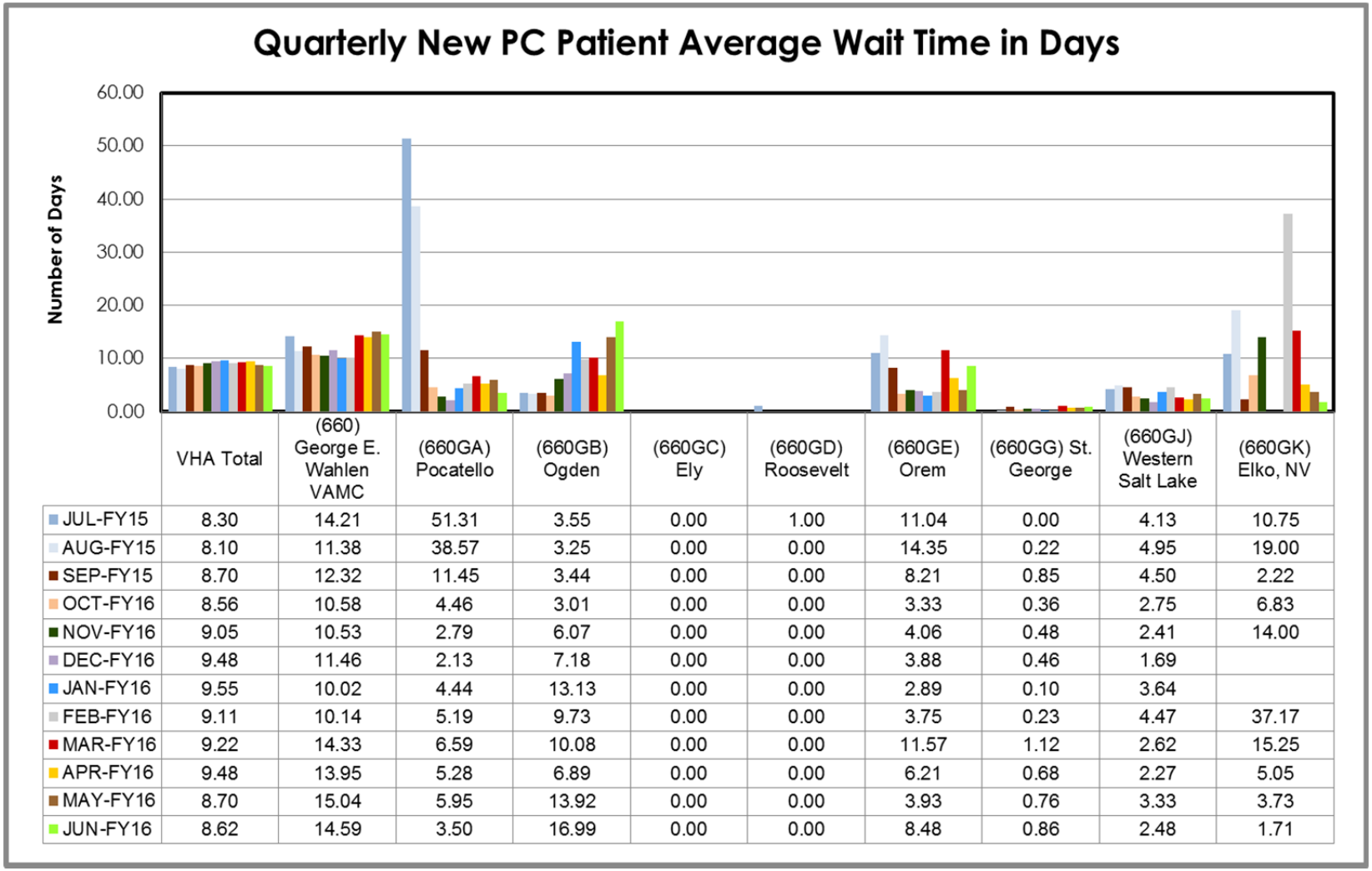
Measure	Definition	Desired Direction
ACSC Hospitalization	Ambulatory care sensitive condition hospitalizations (observed to expected ratio)	A lower value is better than a higher value
Adjusted LOS	Acute care risk adjusted length of stay	A lower value is better than a higher value
Admit Reviews Met	% Acute Admission Reviews that meet InterQual criteria	A higher value is better than a lower 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
Cont Stay Reviews Met	% Acute Continued Stay reviews that meet InterQual criteria	A higher value is better than a lower 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 Like	Outpatient performance measure (HEDIS)	A higher value is better than a lower value
MH Wait Time	MH care wait time for new patient completed appointments within 30 days of preferred date	A higher value is better than a lower value
MH Continuity Care	MH continuity of care (FY14Q3 and later)	A higher value is better than a lower value
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
PC Routine Care Appt	Timeliness in getting a PC routine care appointment (PCMH)	A higher value is better than a lower value
PC Urgent Care Appt	Timeliness in getting a PC urgent care appointment (PCMH)	A higher value is better than a lower value
PC Wait Time	PC wait time for new patient completed appointments within 30 days of preferred date	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
Rating PC Provider	Rating of PC providers (PCMH)	A higher value is better than a lower value
Rating SC Provider	Rating of specialty care providers (specialty care module)	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

Measure	Definition	Desired Direction
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-Cardio	30-day risk standardized readmission rate for cardiorespiratory patient cohort	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-CV	30-day risk standardized readmission rate for cardiovascular patient cohort	A lower value is better than a higher value
RSRR-HWR	Hospital wide readmission	A lower value is better than a higher value
RSRR-Med	30-day risk standardized readmission rate for medicine patient cohort	A lower value is better than a higher value
RSRR-Neuro	30-day risk standardized readmission rate for neurology patient cohort	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
RSRR-Surg	30-day risk standardized readmission rate for surgery patient cohort	A lower value is better than a higher value
SC Routine Care Appt	Timeliness in getting a SC routine care appointment (Specialty Care)	A higher value is better than a lower value
SC Urgent Care Appt	Timeliness in getting a SC urgent care appointment (Specialty Care)	A higher value is better than a lower 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 patient completed appointments within 30 days of preferred date	A higher value is better than a lower value

Source: VHA Support Service Center

Note: We did not assess VA's data for accuracy or completeness.

Patient Aligned Care Team Compass Metrics

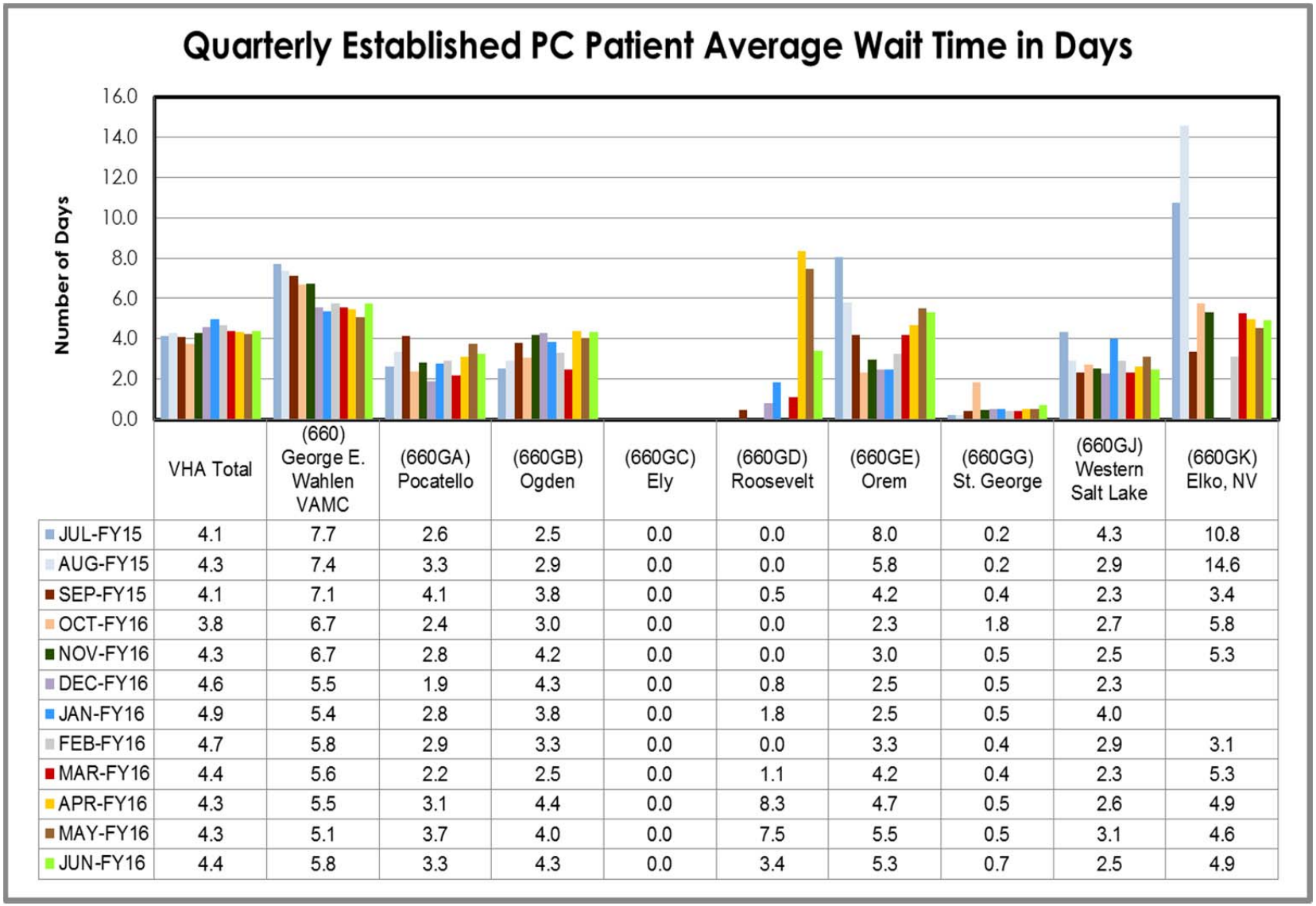


	VHA Total	(660) George E. Wahlen VAMC	(660GA) Pocatello	(660GB) Ogden	(660GC) Ely	(660GD) Roosevelt	(660GE) Orem	(660GG) St. George	(660GJ) Western Salt Lake	(660GK) Elko, NV
JUL-FY15	8.30	14.21	51.31	3.55	0.00	1.00	11.04	0.00	4.13	10.75
AUG-FY15	8.10	11.38	38.57	3.25	0.00	0.00	14.35	0.22	4.95	19.00
SEP-FY15	8.70	12.32	11.45	3.44	0.00	0.00	8.21	0.85	4.50	2.22
OCT-FY16	8.56	10.58	4.46	3.01	0.00	0.00	3.33	0.36	2.75	6.83
NOV-FY16	9.05	10.53	2.79	6.07	0.00	0.00	4.06	0.48	2.41	14.00
DEC-FY16	9.48	11.46	2.13	7.18	0.00	0.00	3.88	0.46	1.69	
JAN-FY16	9.55	10.02	4.44	13.13	0.00	0.00	2.89	0.10	3.64	
FEB-FY16	9.11	10.14	5.19	9.73	0.00	0.00	3.75	0.23	4.47	37.17
MAR-FY16	9.22	14.33	6.59	10.08	0.00	0.00	11.57	1.12	2.62	15.25
APR-FY16	9.48	13.95	5.28	6.89	0.00	0.00	6.21	0.68	2.27	5.05
MAY-FY16	8.70	15.04	5.95	13.92	0.00	0.00	3.93	0.76	3.33	3.73
JUN-FY16	8.62	14.59	3.50	16.99	0.00	0.00	8.48	0.86	2.48	1.71

Source: VHA Support Service Center

Note: We did not assess VA's data for accuracy or completeness.

Data Definition[j]: The average number of calendar days between a new patient's PC completed appointment (clinic stops 322, 323, and 350, excluding Compensation and Pension appointments) and the earliest of three possible preferred (desired) dates (Electronic Wait List (EWL), Cancelled by Clinic Appointment, Completed Appointment) from the completed appointment date. *Note that prior to FY 2015, this metric was calculated using the earliest possible create date.* Blank cells indicate the absence of reported data.

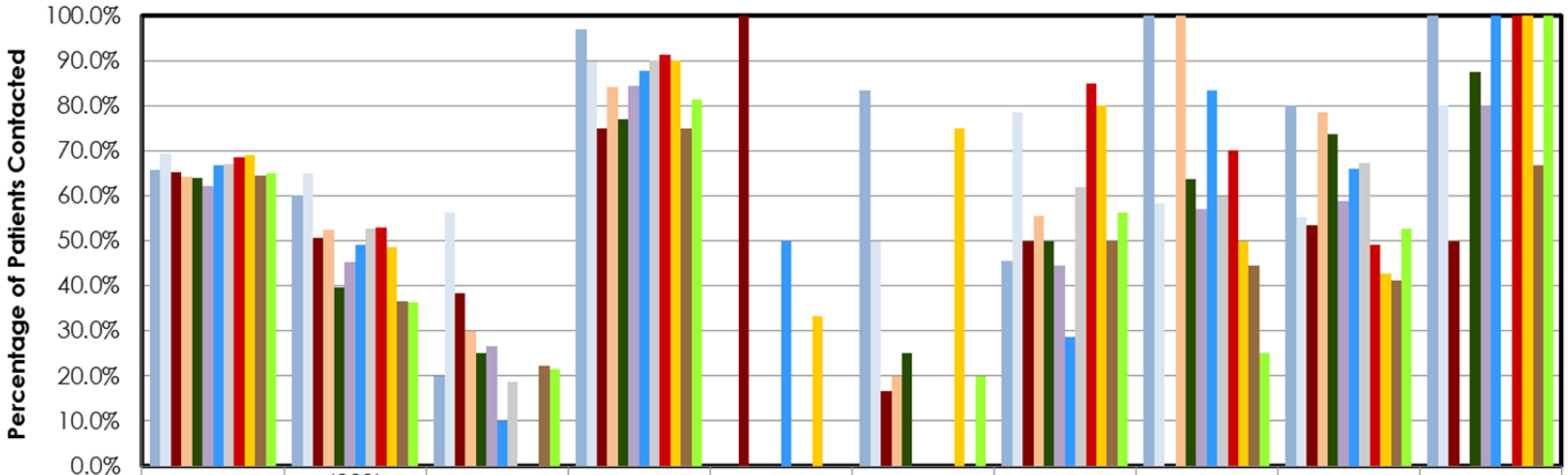


	VHA Total	(660) George E. Wahlen VAMC	(660GA) Pocatello	(660GB) Ogden	(660GC) Ely	(660GD) Roosevelt	(660GE) Orem	(660GG) St. George	(660GJ) Western Salt Lake	(660GK) Elko, NV
JUL-FY15	4.1	7.7	2.6	2.5	0.0	0.0	8.0	0.2	4.3	10.8
AUG-FY15	4.3	7.4	3.3	2.9	0.0	0.0	5.8	0.2	2.9	14.6
SEP-FY15	4.1	7.1	4.1	3.8	0.0	0.5	4.2	0.4	2.3	3.4
OCT-FY16	3.8	6.7	2.4	3.0	0.0	0.0	2.3	1.8	2.7	5.8
NOV-FY16	4.3	6.7	2.8	4.2	0.0	0.0	3.0	0.5	2.5	5.3
DEC-FY16	4.6	5.5	1.9	4.3	0.0	0.8	2.5	0.5	2.3	
JAN-FY16	4.9	5.4	2.8	3.8	0.0	1.8	2.5	0.5	4.0	
FEB-FY16	4.7	5.8	2.9	3.3	0.0	0.0	3.3	0.4	2.9	3.1
MAR-FY16	4.4	5.6	2.2	2.5	0.0	1.1	4.2	0.4	2.3	5.3
APR-FY16	4.3	5.5	3.1	4.4	0.0	8.3	4.7	0.5	2.6	4.9
MAY-FY16	4.3	5.1	3.7	4.0	0.0	7.5	5.5	0.5	3.1	4.6
JUN-FY16	4.4	5.8	3.3	4.3	0.0	3.4	5.3	0.7	2.5	4.9

Source: VHA Support Service Center

Note: We did not assess VA's data for accuracy or completeness.

Data Definition: The average number of calendar days between an established patient's PC completed appointment (clinic stops 322, 323, and 350, excluding Compensation and Pension appointments) and the earliest of three possible preferred (desired) dates (Electronic Wait List (EWL), Cancelled by Clinic Appointment, Completed Appointment) from the completed appointment date. Blank cells indicate the absence of reported data.

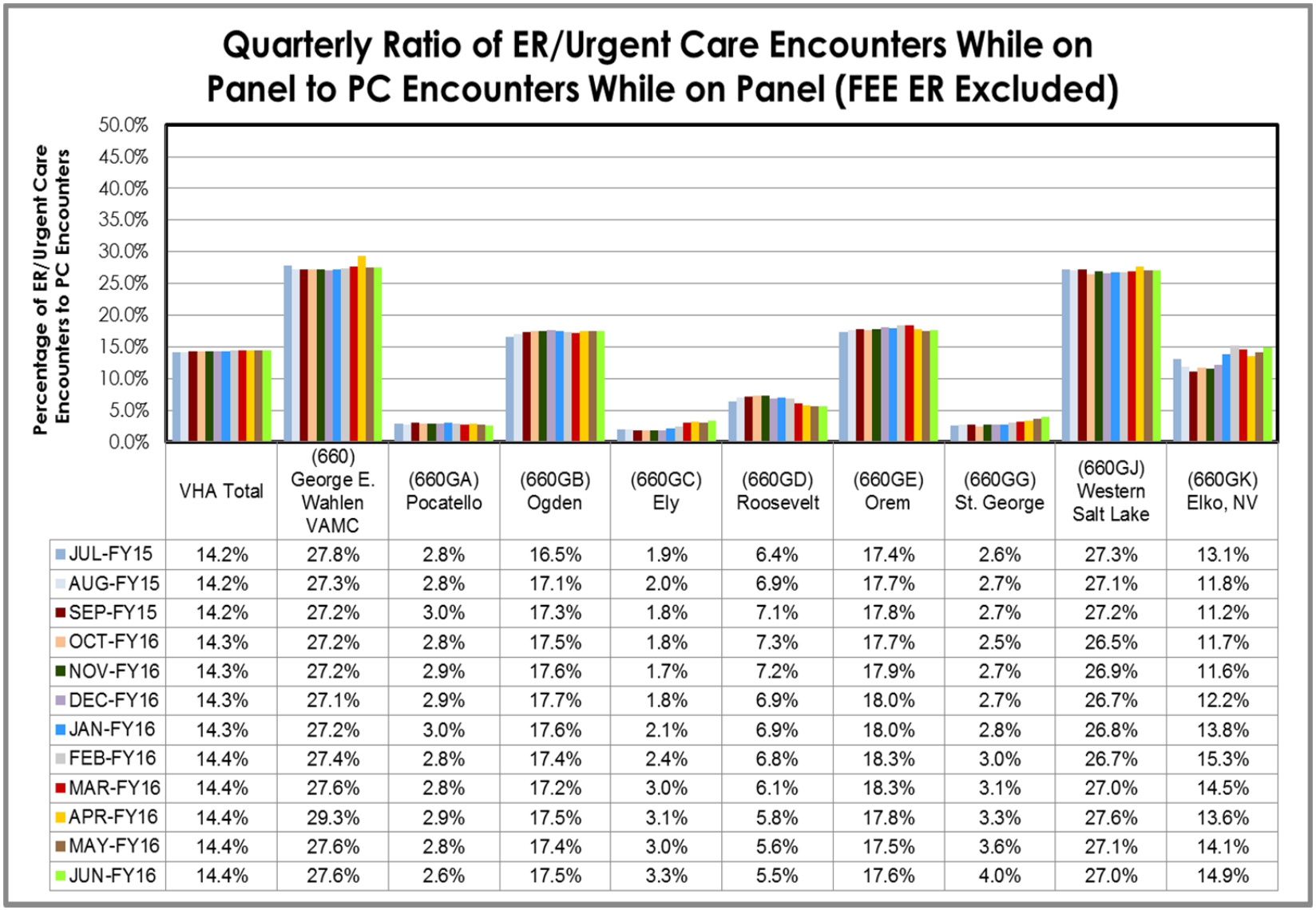


	VHA Total	(660) George E. Wahlen VAMC	(660GA) Pocatello	(660GB) Ogden	(660GC) Ely	(660GD) Roosevelt	(660GE) Orem	(660GG) St. George	(660GJ) Western Salt Lake	(660GK) Elko, NV
JUL-FY15	65.9%	60.2%	20.0%	97.1%	0.0%	83.3%	45.5%	100.0%	80.0%	100.0%
AUG-FY15	69.4%	65.0%	56.3%	89.7%	0.0%	50.0%	78.6%	58.3%	55.4%	80.0%
SEP-FY15	65.1%	50.7%	38.5%	75.0%	100.0%	16.7%	50.0%	0.0%	53.6%	50.0%
OCT-FY16	64.3%	52.4%	30.0%	84.1%	0.0%	20.0%	55.6%	100.0%	78.6%	0.0%
NOV-FY16	64.0%	39.8%	25.0%	76.9%		25.0%	50.0%	63.6%	73.8%	87.5%
DEC-FY16	62.3%	45.2%	26.7%	84.4%	0.0%	0.0%	44.4%	57.1%	59.0%	80.0%
JAN-FY16	66.7%	49.0%	10.0%	87.8%	50.0%	0.0%	28.6%	83.3%	66.0%	100.0%
FEB-FY16	66.9%	52.6%	18.8%	90.0%	0.0%	0.0%	61.9%	60.0%	67.3%	0.0%
MAR-FY16	68.6%	52.9%	0.0%	91.4%	0.0%		85.0%	70.0%	49.2%	100.0%
APR-FY16	69.1%	48.7%	0.0%	90.0%	33.3%	75.0%	80.0%	50.0%	42.9%	100.0%
MAY-FY16	64.5%	36.7%	22.2%	75.0%		0.0%	50.0%	44.4%	41.2%	66.7%
JUN-FY16	64.9%	36.3%	21.4%	81.3%	0.0%	20.0%	56.3%	25.0%	52.7%	100.0%

Source: VHA Support Service Center

Note: We did not assess VA's data for accuracy or completeness.

Data Definition: The percent of assigned PC patients discharged from any VA facility who have been contacted by a PC team member within 2 business days during the reporting period. Patients are excluded if they are discharged from an observation specialty and/or readmitted within 2 business days to any VA facility. Team members must have been assigned to the patient's team at the time of the patient's discharge. Blank cells indicate the absence of reported data.



	VHA Total	(660) George E. Wahlen VAMC	(660GA) Pocatello	(660GB) Ogden	(660GC) Ely	(660GD) Roosevelt	(660GE) Orem	(660GG) St. George	(660GJ) Western Salt Lake	(660GK) Elko, NV
JUL-FY15	14.2%	27.8%	2.8%	16.5%	1.9%	6.4%	17.4%	2.6%	27.3%	13.1%
AUG-FY15	14.2%	27.3%	2.8%	17.1%	2.0%	6.9%	17.7%	2.7%	27.1%	11.8%
SEP-FY15	14.2%	27.2%	3.0%	17.3%	1.8%	7.1%	17.8%	2.7%	27.2%	11.2%
OCT-FY16	14.3%	27.2%	2.8%	17.5%	1.8%	7.3%	17.7%	2.5%	26.5%	11.7%
NOV-FY16	14.3%	27.2%	2.9%	17.6%	1.7%	7.2%	17.9%	2.7%	26.9%	11.6%
DEC-FY16	14.3%	27.1%	2.9%	17.7%	1.8%	6.9%	18.0%	2.7%	26.7%	12.2%
JAN-FY16	14.3%	27.2%	3.0%	17.6%	2.1%	6.9%	18.0%	2.8%	26.8%	13.8%
FEB-FY16	14.4%	27.4%	2.8%	17.4%	2.4%	6.8%	18.3%	3.0%	26.7%	15.3%
MAR-FY16	14.4%	27.6%	2.8%	17.2%	3.0%	6.1%	18.3%	3.1%	27.0%	14.5%
APR-FY16	14.4%	29.3%	2.9%	17.5%	3.1%	5.8%	17.8%	3.3%	27.6%	13.6%
MAY-FY16	14.4%	27.6%	2.8%	17.4%	3.0%	5.6%	17.5%	3.6%	27.1%	14.1%
JUN-FY16	14.4%	27.6%	2.6%	17.5%	3.3%	5.5%	17.6%	4.0%	27.0%	14.9%

Source: VHA Support Service Center

Note: We did not assess VA's data for accuracy or completeness.

Data Definition: This is a measure of where the patient receives his PC and by whom. A low percentage is better. The formula is the total VHA ER/Urgent Care Encounters While on Team (WOT) with a Licensed Independent Practitioner (LIP) *divided by* the number of PC Team Encounters WOT with an LIP **plus** the total number of VHA ER/Urgent Care Encounters WOT with an LIP.

Prior OIG Reports
[January 1, 2014 Through January 1, 2017]

Facility Reports

Audit of the Seismic Safety of VA's Facilities
11/12/2015 | 14-04756-32 | Summary | Report

Review of VHA's Patient-Centered Community Care (PC3) Provider Network Adequacy
9/29/2015 | 15-00718-507 | Summary | Report

Healthcare Inspection – Review of the Operations and Effectiveness of VHA Residential Substance Use Treatment Programs
7/30/2015 | 15-01579-457 | Summary | Report

Community Based Outpatient Clinics Summary Report – Evaluation of Medication Oversight and Education at Community Based Outpatient Clinics and Other Outpatient Clinics
6/18/2015 | 15-01297-368 | Summary | Report

Healthcare Inspection – Improper Procurement and Billing Practices for Anesthesiology Services, George E. Wahlen VA Healthcare System, Salt Lake City, Utah
5/6/2014 | 13-01819-133 | Summary | Report

Appendix E

Veterans Integrated Service Network Director Comments

Department of Veterans Affairs

Memorandum

Date: February 10, 2017

From: Director, Rocky Mountain Network (10N19)

Subject: **CAP Review of the VA Salt Lake City Health Care System, Salt Lake City, UT**

To: Director, Los Angeles Office of Healthcare Inspections (54LA)

Director, Management Review Service (VHA 10E1D MRS Action)

Attached please find the response for the Salt Lake City VA Healthcare System.

I have reviewed and concur with the Medical Center Director's response. Thank you for the opportunity to improve our healthcare organizations.

Ralph T. Gigliotti

Ralph T. Gigliotti, FACHE
Director, VA Rocky Mountain Network (10N19)

Acting Facility Director Comments

Department of Veterans Affairs

Memorandum

Date: February 9, 2017

From: Acting Director, VA Salt Lake City Health Care System (660/00)

Subject: **CAP Review of the VA Salt Lake City Health Care System, Salt Lake City, UT**

To: Director, Rocky Mountain Network (10N19)

I have reviewed the findings within the report of the CAP Review of the VA Salt Lake City Health Care System, Salt Lake City, UT. I am in agreement with the findings of the review.

The plan of corrective actions and target dates has been established.

Shella Stovall

SHELLA STOVALL, MNA, RN
Acting, Medical Center 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 clinical managers consistently review Ongoing Professional Practice Evaluation data semi-annually and that facility managers monitor compliance.

Concur

Target date for completion: Completion date is March 1, 2017. Monitoring for sustained improvement will be until March 1, 2018.

Facility response: The Service has developed a roster of all providers with the date of the last OPPE and when the next OPPE is due for completion. The Roster is maintained on the SharePoint site. The Chief of Staff ensures each service posts and maintains this roster. Every two weeks the Credentialing staff will post an "OPPE Due" list within the Credentialing Committee minutes, which serves to alert the service chief of any OPPE due within 30 days. The Chief of Staff will insure compliance.

Recommendation 2. We recommended that Physician Utilization Management Advisors consistently document their decisions in the National Utilization Management Integration database and that facility managers monitor compliance.

Concur

Target date for completion: Completion date is March 1, 2017. Monitoring for sustained improvement will be until March 1, 2018.

Facility response: Physician Utilization Management Advisors have been briefed on the requirements and the UM Nursing staff will monitor compliance and report non-compliance to the Chief of Staff for corrective action. Decisions will be documented at least 90% of the time.

Recommendation 3. We recommended that Environment of Care Committee meeting minutes consistently document discussion of environment of care rounds deficiencies, the specific deficiencies, corrective actions taken to address identified deficiencies, and resolutions.

Concur

Target date for completion: Completed December 2016. Monitoring for sustained improvement will be until February 1, 2018.

Facility response: EOC Committee meeting agenda has been modified to include the analysis of deficiencies and corrective actions.

Recommendation 4. We recommended that facility managers ensure attendance is documented for all fire drills.

Concur

Target date for completion: Completed December 2016. Monitoring for sustained improvement will be until February 1, 2018.

Facility response: The fire drill evaluation form has been revised to include record keeping of attendance. Drills and documentation of attendance are audited and reported quarterly for compliance.

Recommendation 5. We recommended that facility managers ensure fire drills have documented critiques.

Concur

Target date for completion: Evaluation form modification completed December 2016. Monitoring for sustained improvement will be until February 1, 2018.

Facility response: The fire drill evaluation form has been revised to include critiques. Drills are now conducted using a multi-disciplinary team and managed by Emergency Management. Drills are audited quarterly for compliance. Critiques will be documented at least 90% of the time.

Recommendation 6. We recommended that facility managers ensure eye protection equipment is readily available for employees.

Concur

Target date for completion: Completion date March 31, 2017. Monitoring for sustained improvement will be until February 1, 2018.

Facility response: Following a facility wide assessment, eye protection is now provided at all point of use areas. Compliance will be monitored through environment of care rounds.

Recommendation 7. We recommended that facility managers ensure standard operating procedures for the colonoscopes and endoscopes for esophagogastroduodenoscopy and endoscopic retrograde cholangiopancreatography are consistent with manufacturer instructions for use.

Concur

Target date for completion: Completed January 2017. Monitoring for sustained improvement will be until February 1, 2018.

Facility response: All SOPs are current with competencies developed from the Manufacturers' Instructions.

Recommendation 8. We recommended that Sterile Processing Service managers ensure Sterile Processing Service employees receive training at orientation for the types of reusable medical equipment they reprocess.

Concur

Target date for completion: Completed training module and implemented in January 2017. Monitoring for sustained improvement will be until February 1, 2018.

Facility response: Salt Lake City is participating in a pilot training program for SPS employees. All roles were evaluated for the critical tasks associated with the role and identification of the competencies needed. Employees have all been assigned the training needed for their assigned role. Three new employees have been trained in this manner and other employees are currently in process. The training program will ultimately be Share Point based.

Recommendation 9. We recommended that the facility consistently review and report all quality assurance data measures for the anticoagulation management program quarterly and that facility managers monitor compliance.

Concur

Target date for completion: Completed January 2017. Monitoring for sustained improvement will be until February 1, 2018.

Facility response: A single missing element that was identified involved the reporting on the proportion of patients receiving warfarin going longer than 42 days without INR monitoring. These data are now available from a newly-published national dashboard and are being reported to P&T Committee quarterly along with the other required elements. (First reported quarter one of fiscal year 2017).

Recommendation 10. We recommended that for employees actively involved in the anticoagulant program, clinical managers include in competency assessments knowledge of standard terminology, pharmacology of anticoagulants, monitoring requirements, dose calculation, common side effects, nutrient interactions associated with anticoagulation therapy, and drug to drug interactions associated with anticoagulation therapy and that facility managers monitor compliance.

Concur

Target date for completion: Completed review and update of competency checklists January 2017. Monitoring for sustained improvement will be until February 1, 2018.

Facility response: Existing competency checklists for both nursing and pharmacy staff have been updated to include all required components.

Recommendation 11. We recommended that the facility collect and report data on patient transfers out of the facility.

Concur

Target date for completion: Completed and began data collection in December 2016. Monitoring for sustained improvement will be until February 1, 2018.

Facility response: Data is being collected on transfers out of the facility and reported quarterly to the Performance Improvement Committee.

Recommendation 12. We recommended that the facility monitor and evaluate patient transfers as part of the quality management program.

Concur

Target date for completion: Completed December 2016. Monitoring for sustained improvement will be until February 1, 2018.

Facility response: Data will be collected on transfers out of the facility. Information will be reported at Performance Improvement Committee on a quarterly basis for 12 months and then bi-annually thereafter.

Recommendation 13. We recommended that the Chief of Pathology and Laboratory Medicine Service ensure the point-of-care testing procedure manual is readily available to employees.

Concur

Target date for completion: Completion date February 28, 2017. Monitoring for sustained improvement will be until February 2018.

Facility response: The laboratory has revised the glucose procedure and will deliver a hardcopy of the glucose procedure to each testing location before the end of February.

Recommendation 14. We recommended that the Chief of Pathology and Laboratory Medicine Service ensure employees who perform point-of-care glucose testing comply with facility policy for managing critical glucose values.

Concur

Target date for completion: Completion date February 28, 2017. Monitoring for sustained improvement will be until February 2018.

Facility response: The lab has adjusted the critical value notification target from 100% to 85% in order to establish a near term obtainable goal. Nurse managers will also begin receiving a monthly report (effective March 2017) with nurses/testing personnel not documenting critical value notification (in addition to current daily reports sent). If any testing location fails to meet the 85% target for critical value notification for 3 consecutive months, the glucose meter will be removed from service until the location completes retraining to include proper documentation and notification of critical values.

Recommendation 15. We recommended that providers include history of previous adverse experience with sedation or anesthesia in the history and physical and/or pre-sedation assessment and that facility managers monitor compliance.

Concur

Target date for completion: Completed January 2017. Monitoring for sustained improvement will be until February 1, 2018.

Facility response: Staff re-education has occurred for the Cardiology APCs, Cardiology fellows and attending MDs. The staff was educated about the required documentation for all patients undergoing procedures, which includes the pre-procedure assessment.

Recommendation 16. We recommended that clinical teams, including the providers performing the procedures, conduct and document timeouts using a checklist prior to moderate sedation procedures and that facility managers monitor compliance.

Concur

Target date for completion: To be completed by March 1, 2017. Monitoring for sustained improvement will be until February 1, 2018.

Facility response: Clinical teams, including the providers performing the procedures will conduct and document timeouts using a checklist prior to moderate sedation procedures and facility managers will monitor compliance. Re-education of this group will occur through service chiefs.

Recommendation 17. We recommended that facility managers ensure social workers and registered nurses conduct and document cyclical clinical visits with the frequency required by Veterans Health Administration policy and monitor compliance.

Concur

Target date for completion: Rotational schedule established January 2017. Monitoring for sustained improvement will be until February 1, 2018.

Facility response: Social workers and registered nurses will conduct and document cyclical clinical CNH visits at the frequency required by VHA policy and monitor compliance.

Recommendation 18. We recommended that the Patient Safety Manager and Patient Advocate consistently attend Disruptive Behavior Committee meetings.

Concur

Target date for completion: Completed. Monitoring for sustained improvement will be until February 1, 2018.

Facility response: The Patient Safety Manager or designee will attend the Disruptive Behavior Committee meetings 90% of the time. This will be monitored by the Quality Manager.

Recommendation 19. We recommended that facility clinical managers ensure clinicians inform patients about Patient Record Flags and the right to request to amend/appeal Patient Record Flag placement.

Concur

Target date for completion: Chief of Staff communication to the veteran is our current practice. Having providers reinforce will be completed by February 15, 2017. Monitoring for sustained improvement will be until February 1, 2018.

Facility response: Patients are informed that a Patient Record Flag is being placed in their medical record through a letter by the Chief of Staff. Patients are informed of their right to request an amendment or appeal in that communication. Providers are requested to reinforce that communication during future clinic appointments.

Recommendation 20. We recommended that facility managers ensure all employees receive Level 1 Prevention and Management of Disruptive Behavior training and additional training as required for their assigned risk area within 90 days of hire and that the training is documented in employee training records.

Concur

Target date for completion: Process for education of staff has been completed January 2017. Monitoring for sustained improvement will be until February 1, 2018.

Facility response: The education department reviewed staff learning plans for correct assignment of PMDB and corrected any errors. All classes for new employees will be scheduled in New Employee Orientation (NEO) with emails sent out to managers to inform dates the new employee is to attend these classes. The education department will pull monthly compliance reports from TMS and send emails out to individuals who have not taken the required courses and their managers.

In addition, the department has established a timeline for informing service chiefs to be informed of staff that has not completed their PMDB requirements. They will further notify the Senior Leadership Team of staff who fail to comply with training requirements. Enforcement of these requirements will include suspension of access to the computer system until compliance.

OIG 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] The references used for QSV included:
- 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 EOC included:
- VA Handbook 6500, *Risk Management Framework for VA Information Systems – Tier 3: VA Information Security Program*, March 10, 2015.
- VHA Directive 1116(2), *Sterile Processing Services (SPS)*, March 23, 2016.
- VHA Directive 7704(1); *Location, Selection, Installation, Maintenance, and Testing of Emergency Eyewash and Shower Equipment*; February 16, 2016.
- Various requirements of The Joint Commission, Centers for Disease Control and Prevention, Occupational Safety and Health Administration, International Association of Healthcare Central Service Materiel Management, Health Insurance Portability and Accountability Act, National Fire Protection Association.

[c] The references used for Medication Management: Anticoagulation Therapy included:
- VHA Directive 1026; *VHA Enterprise Framework for Quality, Safety, and Value*; August 2, 2013.
- VHA Directive 1033, *Anticoagulation Therapy Management*, July 29, 2015.
- VHA Directive 1088, *Communicating Test Results to Providers and Patients*, October 7, 2015.

[d] The references used for Coordination of Care: Inter-Facility Transfers included:
- VHA Directive 2007-015, *Inter-Facility Transfer Policy*, May 7, 2007.
- VHA Handbook 1907.01, *Health Information Management and Health Records*, March 19, 2015.
- VHA Handbook 1400.01, *Resident Supervision*, December 19, 2012.

[e] The references used for Diagnostic Care: POCT included:
- VHA Handbook 1106.01, *Pathology and Laboratory Medicine Service Procedures*, October 6, 2008.
- VHA Handbook 1106.01, *Pathology and Laboratory Medicine Service (P&LMS) Procedures*, January 29, 2016.
- VHA Directive 1088, *Communicating Test Results to Providers and Patients*, October 7, 2015.
- The Joint Commission. *Comprehensive Accreditation Manual for Laboratories and Point-of-Care Testing*. Update 2. September 2010.
- Boaz M, Landau Z, Wainstein J. Analysis of Institutional Blood Glucose Surveillance. *Journal of Diabetes Science and Technology*. 2010;4(6):1,514–15. Accessed July 18, 2016.

[f] The references used for Moderate Sedation included:
- VHA Handbook 1004.01, *Informed Consent for Clinical Treatments and Procedures*, August 14, 2009.
- VHA Directive1039, *Ensuring Correct Surgery and Invasive Procedures*, July 26, 2013.
- VHA Directive 1073, *Moderate Sedation by Non-Anesthesia Providers*, December 30, 2014.
- VHA Directive 1177; *Cardiopulmonary Resuscitation, Basic Life Support, and Advanced Cardiac Life Support Training for Staff*; November 6, 2014.
- VA National Center for Patient Safety. *Facilitator's Guide for Moderate Sedation Toolkit for Non-Anesthesiologists*. March 29, 2011.
- American Society of Anesthesiologists. Practice Guidelines for Sedation and Analgesia by Non-Anesthesiologists. *Anesthesiology*. 2002; 96:1004–17.
- The Joint Commission. Hospital Standards. January 2016. PC.03.01.01, EP1 and MS.06.01.03 EP6.

[g] The references used for CNH Oversight included:
- VHA Handbook 1143.2, *VHA Community Nursing Home Oversight Procedures*, June 4, 2004.
- VA OIG report, *Healthcare Inspection – Evaluation of the Veterans Health Administration's Contact Community Nursing Home Program*, (Report No. 05-00266-39, December 13, 2007).

[h] The references used for Management of Disruptive/Violent Behavior included:

- VHA Directive 2012-026, *Sexual Assaults and Other Defined Public Safety Incidents in Veterans Health Administration (VHA) Facilities*, September 27, 2012.
- Public Law 112-154. Honoring America's Veterans and Caring for Camp Lejeune Families Act of 2012. August 6, 2012. 126 Stat. 1165. Sec. 106.
- Acting Deputy Under Secretary for Health for Operations and Management. "Meeting New Mandatory Safety Training Requirements using Veterans Health Administration's Prevention and Management of Disruptive Behavior (PMDB) Curriculum." memorandum. November 7, 2013.

[i] The reference used for the Strategic Analytics for Improvement and Learning (SAIL) metric definitions was:

- VHA Support Service Center (VSSC), Strategic Analytics for Improvement and Learning (SAIL), accessed: October 3, 2016.

[j] The reference used for PACT Compass data graphs was:

- Department of Veterans' Affairs, Patient Aligned Care Teams Compass Data Definitions, accessed: February 25, 2016.