



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

Office of Healthcare Inspections

Report No. 13-00278-164

**Combined Assessment Program
Review of the
Dayton VA Medical Center
Dayton, Ohio**

April 4, 2013

Washington, DC 20420

To Report Suspected Wrongdoing in VA Programs and Operations

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(Hotline Information: www.va.gov/oig/hotline)

Glossary

CAP	Combined Assessment Program
CLC	community living center
CPR	cardiopulmonary resuscitation
CS	controlled substances
EHR	electronic health record
EOC	environment of care
facility	Dayton VA Medical Center
FPPE	Focused Professional Practice Evaluation
FY	fiscal year
HPC	hospice and palliative care
LIP	licensed independent practitioner
NA	not applicable
NC	noncompliant
OIG	Office of Inspector General
PCCT	Palliative Care Consult Team
PSB	Professional Standards Board
QM	quality management
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

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Executive Summary

Review Purpose: The purpose of the review was to evaluate selected health care facility operations, focusing on patient care quality and the environment of care, and to provide crime awareness briefings. We conducted the review the week of January 28, 2013.

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

- Long-Term Home Oxygen Therapy
- Nurse Staffing

The facility's reported accomplishments were hospice and palliative care program comfort items and the Orthopedic Surgery Department System Redesign Project.

Recommendations: We made recommendations in the following five activities:

Quality Management: Ensure that Focused Professional Practice Evaluations for newly hired licensed independent practitioners are consistently initiated and that results are consistently reported to the Professional Standards Board. Include all required elements in the scanning quality control process. Consistently scan the results of non-VA purchased diagnostic tests into electronic health records. Ensure clinicians perform and document patient assessments following blood product transfusions. Complete code evaluation sheets for all code episodes.

Environment of Care: Ensure that Environment of Care Committee minutes reflect sufficient discussion of findings, action plans, and tracking of items to closure.

Medication Management – Controlled Substances Inspections: Initiate actions to address the 12 identified deficiencies, and correct all deficiencies identified during annual physical security surveys.

Coordination of Care – Hospice and Palliative Care: Ensure that all non-hospice and palliative care staff receive end-of-life training. Establish a process to track hospice and palliative care consults that are not acted upon within the requested timeframe. Consistently assess hospice and palliative care inpatients' pain, document results in electronic health records, and monitor compliance.

Preventable Pulmonary Embolism: Initiate protected peer review for the three identified patients, and complete any recommended review actions.

Comments

The Veterans Integrated Service Network and Facility Directors agreed with the Combined Assessment Program review findings and recommendations and provided acceptable improvement plans. (See Appendixes C and D, pages 15–21, for the full text of the Directors' comments.) We will follow up on the planned actions until they are completed.



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

Objectives and Scope

Objectives

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

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

Scope

We reviewed selected clinical and administrative activities to evaluate compliance with requirements related to patient care quality and the EOC. In performing the review, we inspected selected areas, interviewed managers and employees, and reviewed clinical and administrative records. The review covered the following seven activities:

- QM
- EOC
- Medication Management – CS Inspections
- Coordination of Care – HPC
- Long-Term Home Oxygen Therapy
- Nurse Staffing
- Preventable Pulmonary Embolism

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

The review covered facility operations for FY 2011, FY 2012, and FY 2013 through February 1, 2013, and was done in accordance with OIG standard operating procedures for CAP reviews. We also asked the facility to provide the status on the recommendations we made in our previous CAP report (*Combined Assessment Program Review of the Dayton VA Medical Center, Dayton, Ohio, Report No. 10-01173-203, July 22, 2010*). We made a repeat recommendation in QM.

During this review, we presented crime awareness briefings for 446 employees. These briefings covered procedures for reporting suspected criminal activity to the OIG and

included case-specific examples illustrating procurement fraud, conflicts of interest, and bribery.

Additionally, we surveyed employees regarding patient safety and quality of care at the facility. An electronic survey was made available to all facility employees, and 270 responded. We shared survey results with facility managers.

In this report, we make recommendations for improvement. Recommendations pertain to issues that are significant enough to be monitored by the OIG until corrective actions are implemented.

Reported Accomplishments

HPC Program

The HPC program provides Comfort Carts in each veteran care area. These carts are for families to use during their stay. They contain a variety of items, including personal care items, snacks, spiritual and grief support items, and relaxation items for adults and children, to ease families' time on the unit. The carts also include phone cards, iPads with internet access, local newspapers, and magazines.

The HPC program also uses the Bobby's Books program as a support strategy for young children and grandchildren of veterans. Children are provided with a book and a blanket to help comfort and support them through the loss of their parent or grandparent.

Orthopedic Surgery Department System Redesign

A multidisciplinary system redesign team was developed to improve the quality of the Orthopedic Surgery Department by decreasing wait times and inefficiencies in the system. Changes that the team made included opening lines of communication for all involved in the process, standardizing surgical guidelines coordination of care throughout VISN 10, adding orthopedic surgery slots, revising surgical instrument trays for quicker turnover time, and adjusting the orthopedic surgical waitlist by removing patients who no longer needed/wanted surgery. The improvements made through this system redesign have resulted in decreased wait time for orthopedic surgery from 18 months in December 2010 to the current 2 months.

Results and Recommendations

QM

The purpose of this review was to determine whether facility senior managers actively supported and appropriately responded to QM efforts and whether the facility complied with selected requirements within its QM program.¹

We interviewed senior managers and key QM employees, and we evaluated meeting minutes, EHRs, and other relevant documents. The table below shows the areas reviewed for this topic. The areas marked as NC needed improvement. Items that did not apply to this facility are marked "NA."

NC	Areas Reviewed	Findings
	There was a senior-level committee/group responsible for QM/performance improvement, and it included the required members.	
	There was evidence that Inpatient Evaluation Center data was discussed by senior managers.	
	Corrective actions from the protected peer review process were reported to the Peer Review Committee.	
X	FPPEs for newly hired LIPs complied with selected requirements.	Eight LIP profiles reviewed: <ul style="list-style-type: none"> • Two FPPEs were not initiated. • Of the five completed FPPEs, results of three were not reported to the PSB. This was a repeat finding from the previous CAP review.
	Local policy for the use of observation beds complied with selected requirements.	
	Data regarding appropriateness of observation bed use was gathered, and conversions to acute admissions were less than 30 percent.	
	Staff performed continuing stay reviews on at least 75 percent of patients in acute beds.	
	Appropriate processes were in place to prevent incidents of surgical items being retained in a patient following surgery.	
	The CPR review policy and processes complied with requirements for reviews of episodes of care where resuscitation was attempted.	
	There was an EHR quality review committee, and the review process complied with selected requirements.	
	The EHR copy and paste function was monitored.	

NC	Areas Reviewed (continued)	Findings
X	Appropriate quality control processes were in place for non-VA care documents, and the documents were scanned into EHRs.	<ul style="list-style-type: none"> • The scanning quality control process did not address scanned document image quality, legibility, linkage (to the correct record), and indexing. Thirty EHRs of patients who had non-VA purchased diagnostic tests reviewed: <ul style="list-style-type: none"> • Seven (23 percent) test results were not scanned into the EHRs.
X	Use and review of blood/transfusions complied with selected requirements.	Twenty-seven EHRs of patients who received blood products reviewed: <ul style="list-style-type: none"> • Four EHRs did not contain documentation of patient assessments following blood transfusions.
	CLC minimum data set forms were transmitted to the data center with the required frequency.	
	Overall, if significant issues were identified, actions were taken and evaluated for effectiveness.	
	There was evidence at the senior leadership level that QM, patient safety, and systems redesign were integrated.	
	Overall, there was evidence that senior managers were involved in performance improvement over the past 12 months.	
X	The facility complied with any additional elements required by VHA or local policy.	Nine months of CPR episodes of care reviewed: <ul style="list-style-type: none"> • Evaluation sheets were not completed for 10 of 36 (28 percent) codes as required by local policy.

Recommendations

1. We recommended that processes be strengthened to ensure that FPPEs for newly hired LIPs are consistently initiated and that results are consistently reported to the PSB.
2. We recommended that the scanning quality control process includes all required elements.
3. We recommended that processes be strengthened to ensure that the results of non-VA purchased diagnostic tests are consistently scanned into EHRs.
4. We recommended that processes be strengthened to ensure that clinicians perform and document patient assessments following blood product transfusions.
5. We recommended that processes be strengthened to ensure that code evaluation sheets are completed for all code episodes.

EOC

The purpose of this review was to determine whether the facility maintained a clean and safe health care environment in accordance with applicable requirements.²

We inspected the Women’s Health Center; the emergency department; and the physical therapy, occupational therapy, and chemotherapy clinics. We also inspected the medical/telemetry (3S), intensive care, surgery (4N), CLC/dementia, and locked mental health (7S) units. Additionally, we reviewed relevant documents and interviewed key employees and managers. The table below shows the areas reviewed for this topic. The area marked as NC needed improvement. Items that did not apply to this facility are marked “NA.”

NC	Areas Reviewed for General EOC	Findings
X	EOC Committee minutes reflected sufficient detail regarding identified deficiencies, corrective actions taken, and tracking of corrective actions to closure.	Six months of EOC Committee meeting minutes reviewed: <ul style="list-style-type: none"> • Minutes did not reflect sufficient discussion of findings, action plans, and tracking of items to closure.
	An infection prevention risk assessment was conducted, and actions were implemented to address high-risk areas.	
	Infection Prevention/Control Committee minutes documented discussion of identified problem areas and follow-up on implemented actions and included analysis of surveillance activities and data.	
	The facility had a policy that detailed cleaning of equipment between patients.	
	Patient care areas were clean.	
	Fire safety requirements were met.	
	Environmental safety requirements were met.	
	Infection prevention requirements were met.	
	Medication safety and security requirements were met.	
	Sensitive patient information was protected, and patient privacy requirements were met.	
	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.	
	Areas Reviewed for the Women’s Health Clinic	
	The Women Veterans Program Manager completed required annual EOC evaluations, and the facility tracked women’s health-related deficiencies to closure.	
	Fire safety requirements were met.	
	Environmental safety requirements were met.	
	Infection prevention requirements were met.	

NC	Areas Reviewed for the Women’s Health Clinic (continued)	Findings
	Medication safety and security requirements were met.	
	Patient privacy requirements were met.	
	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.	
	Areas Reviewed for Physical Medicine and Rehabilitation Therapy Clinics	
	Fire safety requirements were met.	
	Environmental safety requirements were met.	
	Infection prevention requirements were met.	
	Medication safety and security requirements were met.	
	Patient privacy requirements were met.	
	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.	

Recommendation

6. We recommended that processes be strengthened to ensure that EOC Committee minutes reflect sufficient discussion of findings, action plans, and tracking of items to closure.

Medication Management – CS Inspections

The purpose of this review was to determine whether the facility complied with requirements related to CS security and inspections.³

We reviewed relevant documents and interviewed key employees. We also reviewed the training files of all CS Coordinators and 10 CS inspectors and inspection documentation from 10 CS areas, the inpatient and outpatient pharmacies, and the emergency drug cache. The table below shows the areas reviewed for this topic. The area marked as NC needed improvement. Items that did not apply to this facility are marked “NA.”

NC	Areas Reviewed	Findings
	Facility policy was consistent with VHA requirements.	
X	VA police conducted annual physical security surveys of the pharmacy/pharmacies, and any identified deficiencies were corrected.	Annual physical security surveys for past 2 years reviewed. <ul style="list-style-type: none"> • Twelve identified deficiencies had not been corrected, and managers reported that the non-recurring maintenance projects were not funded. However, a funding request was submitted for FY 2015.
	Instructions for inspecting automated dispensing machines were documented, included all required elements, and were followed.	
	Monthly CS inspection findings summaries and quarterly trend reports were provided to the facility Director.	
	CS Coordinator position description(s) or functional statement(s) included duties, and CS Coordinator(s) completed required certification and were free from conflicts of interest.	
	CS inspectors were appointed in writing, completed required certification and training, and were free from conflicts of interest.	
	Non-pharmacy areas with CS were inspected in accordance with VHA requirements, and inspections included all required elements.	
	Pharmacy CS inspections were conducted in accordance with VHA requirements and included all required elements.	
	The facility complied with any additional elements required by VHA or local policy.	

Recommendation

7. We recommended that managers initiate actions to address the 12 identified deficiencies and that processes be strengthened to ensure that all deficiencies identified during annual physical security surveys are corrected.

Coordination of Care – HPC

The purpose of this review was to determine whether the facility complied with selected requirements related to HPC, including PCCT, consults, and inpatient services.⁴

We reviewed relevant documents, 20 EHRs of patients who had PCCT consults (including 10 HPC inpatients), and 24 employee training records (9 HPC staff records and 15 non-HPC staff records), and we interviewed key employees. The table below shows the areas reviewed for this topic. The areas marked as NC needed improvement. Items that did not apply to this facility are marked “NA.”

NC	Areas Reviewed	Findings
	A PCCT was in place and had the dedicated staff required.	
	The PCCT actively sought patients appropriate for HPC.	
	The PCCT offered end-of-life training.	
X	HPC staff and selected non-HPC staff had end-of-life training.	<ul style="list-style-type: none"> Of the 15 non-HPC staff, there was no evidence that 9 had end-of-life training.
	The facility had a VA liaison with community hospice programs.	
	The PCCT promoted patient choice of location for hospice care.	
	The CLC-based hospice program offered bereavement services.	
	The HPC consult contained the word “palliative” or “hospice” in the title.	
	HPC consults were submitted through the Computerized Patient Record System.	
X	The PCCT responded to consults within the required timeframe and tracked consults that had not been acted upon.	<ul style="list-style-type: none"> Three consults were not acted upon within the requested timeframe and had not been tracked.
	Consult responses were attached to HPC consult requests.	
	The facility submitted the required electronic data for HPC through the VHA Support Service Center.	
	An interdisciplinary team care plan was completed for HPC inpatients within the facility’s specified timeframe.	
X	HPC inpatients were assessed for pain with the frequency required by local policy.	<ul style="list-style-type: none"> Six EHRs did not contain documentation of pain assessments conducted with the frequency required by local policy.
	HPC inpatients’ pain was managed according to the interventions included in the care plan.	
	HPC inpatients were screened for an advanced directive upon admission and according to local policy.	

NC	Areas Reviewed (continued)	Findings
	The facility complied with any additional elements required by VHA or local policy.	

Recommendations

- 8. We recommended that processes be strengthened to ensure that all non-HPC staff receive end-of-life training.
- 9. We recommended that a process be established to track HPC consults that are not acted upon within the requested timeframe.
- 10. We recommended that processes be strengthened to ensure that HPC inpatients' pain is consistently assessed and results documented in EHRs and that compliance be monitored.

Long-Term Home Oxygen Therapy

The purpose of this review was to determine whether the facility complied with requirements for long-term home oxygen therapy in its mandated Home Respiratory Care Program.⁵

We reviewed relevant documents and 34 EHRs of patients enrolled in the home oxygen program (including 16 patients deemed to be high risk), and we interviewed key employees. The table below shows the areas reviewed for this topic. Items that did not apply to this facility are marked “NA.” The facility generally met requirements. We made no recommendations.

NC	Areas Reviewed	Findings
	There was a local policy to reduce the fire hazards of smoking associated with oxygen treatment.	
	The Chief of Staff reviewed Home Respiratory Care Program activities at least quarterly.	
	The facility had established a home respiratory care team.	
	Contracts for oxygen delivery contained all required elements and were monitored quarterly.	
	Home oxygen program patients had active orders/prescriptions for home oxygen and were re-evaluated for home oxygen therapy annually after the first year.	
	Patients identified as high risk received hazards education at least every 6 months after initial delivery.	
	NC high-risk patients were identified and referred to a multidisciplinary clinical committee for review.	
	The facility complied with any additional elements required by VHA or local policy.	

Nurse Staffing

The purpose of this review was to determine the extent to which the facility implemented the staffing methodology for nursing personnel and to evaluate nurse staffing on two selected units (acute care and long-term care).⁶

We reviewed relevant documents and 42 training files, and we interviewed key employees. Additionally, we reviewed the actual nursing hours per patient day for acute care unit 3S and CLC unit Tall Pines for 50 randomly selected days (holidays, weekdays, and weekend days) between October 1, 2011, and September 30, 2012. The table below shows the areas reviewed for this topic. Items that did not apply to this facility are marked “NA.” The facility generally met requirements. We made no recommendations.

NC	Areas Reviewed	Findings
	The unit-based expert panels followed the required processes.	
	The facility expert panel followed the required processes and included all required members.	
	Members of the expert panels completed the required training.	
	The facility completed the required steps to develop a nurse staffing methodology by September 30, 2011.	
	The selected units' actual nursing hours per patient day met or exceeded the target nursing hours per patient day.	
	The facility complied with any additional elements required by VHA or local policy.	

Preventable Pulmonary Embolism

The purpose of this review was to evaluate the care provided to patients who were treated at the facility and developed potentially preventable pulmonary embolism.⁷

We reviewed relevant documents and 28 EHRs of patients with confirmed diagnoses of pulmonary embolism^a January 1–June 30, 2012. We also interviewed key employees. The table below shows the areas reviewed for this topic. The area marked as NC needed improvement. Items that did not apply to this facility are marked “NA.”

NC	Areas Reviewed	Findings
X	Patients with potentially preventable pulmonary emboli received appropriate anticoagulation medication prior to the event.	<ul style="list-style-type: none"> Three patients were identified as having potentially preventable pulmonary emboli because they had risk factors and had not been provided anticoagulation medication.
	No additional quality of care issues were identified with the patients' care.	
	The facility complied with any additional elements required by VHA or local policy/protocols.	

Recommendation

11. We recommended that managers initiate protected peer review for the three identified patients and complete any recommended review actions.

^a A sudden blockage in a lung artery usually caused by a blood clot that travels to the lung from a vein in the body, most commonly in the legs.

Facility Profile (Dayton/552) FY 2012^b	
Type of Organization	Secondary
Complexity Level	1c-High complexity
Affiliated/Non-Affiliated	Affiliated
Total Medical Care Budget in Millions (through August 2012)	\$317.3
Number of:	
• Unique Patients	37,520
• Outpatient Visits	443,376
• Unique Employees^c (as of last pay period in FY 2012)	1,668
Type and Number of Operating Beds:	
• Hospital	120
• CLC	225
• Mental Health	115
Average Daily Census: (through August 2012)	
• Hospital	65
• CLC	132
• Mental Health	83
Number of Community Based Outpatient Clinics	4
Location(s)/Station Number(s)	Middletown/552GA Lima/552GB Richmond/552GC Springfield/552GD
VISN Number	10

^b All data is for FY 2012 except where noted.

^c Unique employees involved in direct medical care (cost center 8200).

VHA Patient Satisfaction Survey

VHA has identified patient satisfaction scores as significant indicators of facility performance. Patients are surveyed monthly. Table 1 below shows facility, VISN, and VHA overall inpatient and outpatient satisfaction scores for FY 2012.

Table 1

	Inpatient Scores		Outpatient Scores			
	FY 2012		FY 2012			
	Inpatient Score Quarters 1–2	Inpatient Score Quarters 3–4	Outpatient Score Quarter 1	Outpatient Score Quarter 2	Outpatient Score Quarter 3	Outpatient Score Quarter 4
Facility	60.4	55.2	52.7	53.8	54.4	50.5
VISN	64.2	63.4	59.9	59.6	59.2	58.3
VHA	63.9	65.0	55.0	54.7	54.3	55.0

Hospital Outcome of Care Measures

Hospital Outcome of Care Measures show what happened after patients with certain conditions received hospital care.^d Mortality (or death) rates focus on whether patients died within 30 days of being hospitalized. Readmission rates focus on whether patients were hospitalized again within 30 days of their discharge. These rates are based on people who are 65 and older and are “risk-adjusted” to take into account how sick patients were when they were initially admitted. Table 2 below shows facility and U.S. national Hospital Outcome of Care Measure rates for patients discharged between July 1, 2008, and June 30, 2011.^e

Table 2

	Mortality			Readmission		
	Heart Attack	Heart Failure	Pneumonia	Heart Attack	Heart Failure	Pneumonia
Facility	16.4	10.9	11.6	21.4	25.6	18.1
U.S. National	15.5	11.6	12.0	19.7	24.7	18.5

^d A heart attack occurs when blood flow to a section of the heart muscle becomes blocked, and the blood supply is slowed or stopped. If the blood flow is not restored timely, the heart muscle becomes damaged. Heart failure is a weakening of the heart’s pumping power. Pneumonia is a serious lung infection that fills the lungs with mucus and causes difficulty breathing, fever, cough, and fatigue.

^e Rates were calculated from Medicare data and do not include data on people in Medicare Advantage Plans (such as health maintenance or preferred provider organizations) or people who do not have Medicare.

VISN Director Comments

**Department of
Veterans Affairs**

Memorandum

Date: March 20, 2013

From: Director, VA Healthcare System of Ohio (10N10)

Subject: **CAP Review of the Dayton VA Medical Center, Dayton, OH**

To: Director, Baltimore Office of Healthcare Inspections (54BA)
Director, Management Review Service (VHA 10AR MRS
OIG CAP CBOC)

1. I have reviewed the draft report of the Combined Assessment Program Review of the Dayton VA Medical Center Dayton, Ohio. I concur with the recommendations and the Medical Center Director's response.
2. Thank you for this opportunity of review, focused towards continuous performance improvement. If you have any questions, please contact Lisa Durham, Chief, Quality Management, Dayton VAMC at (937) 268-6511, extension 7630.

(original signed by:)
Jack G. Hetrick, FACHE
Network Director
VISN 10

Facility Director Comments

**Department of
Veterans Affairs**

Memorandum

Date: March 19, 2013
From: Director, Dayton VA Medical Center (552/00)
Subject: **CAP Review of the Dayton VA Medical Center, Dayton, OH**
To: Director, VA Healthcare System of Ohio (10N10)

1. Thank you for the opportunity to review the draft report of the Combined Assessment Program Review of the Dayton VA Medical Center, Dayton, Ohio.
2. I have reviewed the document and concur with the recommendations. Corrective action plans have been established with planned completion dates, as detailed in the attached report.
3. If you have any questions, please contact Lisa Durham, Chief Quality Management at (937) 268-6511, extension 7630.

(original signed by:)
Glenn A. Costie, FACHE
CEO / 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 processes be strengthened to ensure that FPPEs for newly hired LIPs are consistently initiated and that results are consistently reported to the PSB.

Concur

Target date for completion: September 30, 2013

The December 12, 2012 PSB established and approved two new FPPE templates: one for communicating the initiation of FPPE and one for the communicating the completion of FPPE. This new process was communicated to the appropriate Service Chiefs on December 12, 2012. All backlogs of overdue FPPE reports were addressed and now stand current. All FPPE reports are tracked on the MS Excel data base until they are closed in the PSB minutes. The AA to the Chief of Staff will do a monthly monitor for six months to compare the PSB minutes with the MS Excel data base to assure that all required FPPE are initiated, completed and reported in the PSB minutes. The monitor results will be reported monthly to the Clinical Executive Board.

Recommendation 2. We recommended that the scanning quality control process includes all required elements.

Concur

Target date for completion: September 30, 2013

The OIG reviewer found the review format for the scanning quality control process to be confusing and suggested improvements. The changes were made the same day and shared with the reviewer. Our current monitor includes all required elements for the scanning quality control process. The monitor results will be reported monthly for six months to the Medical Records Review Committee.

Recommendation 3. We recommended that processes be strengthened to ensure that the results of non-VA purchased diagnostic tests are consistently scanned into EHRs.

Concur

Target date for completion: September 30, 2013

The VISN Non-VA Medical Care Office and the facility Health Information Management Service (HIMS) will review Non-VA cases and ensure that the results of purchased

diagnostic tests are consistently scanned into the Electronic Health Record (EHR). A random sample of cases will be monitored monthly by the facility HIMS staff to assure that diagnostic test results are scanned into the EHR for six months. The monitor results will be reported quarterly to the Medical Records Committee for two quarters. Any barriers to success will be identified and adjustments to the process will be made if necessary.

Recommendation 4. We recommended that processes be strengthened to ensure that clinicians perform and document patient assessments following blood product transfusions.

Concur

Target date for completion: October 31, 2013

A post blood transfusion assessment template will be in place for use by April 15, 2013. By April 30, 2013 all physicians will be re educated on the requirement of a documented post transfusion patient outcome assessment utilizing the new template. Education will include E-mail, discussion during the April 9, 2013 Clinical Executive Board, and discussion during the April 18, 2013 Quarterly Medical Staff meeting. The Blood Bank Program Manager will monitor the use of the post transfusion assessment template monthly for six months. The monitor results will be reported monthly to the Clinical Executive Board and quarterly for two quarters to the Blood Utilization Committee.

Recommendation 5. We recommended that processes be strengthened to ensure that code evaluation sheets are completed for all code episodes.

Concur

Target date for completion: September 30, 2013

All codes are reported daily at the nursing morning report and code evaluation sheets are given to the Risk Manager or designee. The code data is entered into the Risk Management database as verification of the receipt of the code evaluation form. The Risk Manager will monitor monthly for six months to assure all code evaluation sheets are received by QM. The monitor results will be included in the quarterly CPR data report for two quarters. The CPR data is reported to the Special Care Units Committee and Performance Improvement Committee.

Recommendation 6. We recommended that processes be strengthened to ensure that EOC Committee minutes reflect sufficient discussion of findings, action plans, and tracking of items to closure.

Concur

Target date for completion: September 30, 2013

The EOC and Safety Committee will initiate an action tracking tool that includes open items, required actions, responsible parties, and completion dates. The committee's discussion of agenda items will be captured in the minutes. The EOC and Safety Committee minutes will be forwarded monthly for six months to Quality Management Service for monitoring of the utilization of the action tracking tool and to review documentation of committee discussion of findings. This monitoring will continue for six months to assure consistent improved action item tracking and improved documentation is established. The monitor results will be reported monthly to the Administrative Executive Board.

Recommendation 7. We recommended that managers initiate actions to address the 12 identified deficiencies and that processes be strengthened to ensure that all deficiencies identified during annual physical security surveys are corrected.

Concur

Target date for completion: September 30, 2013

The 12 deficiencies that were identified during the OIG review now have work orders submitted. The target completion date for addressing all of the 12 deficiencies is the end of FY 13. These 12 deficiencies and all future deficiencies identified from the Annual Physical Security Surveys will be reported to the EOC and Safety Committee where they will be tracked to closure on the action tracking tool. "Annual Physical Security Survey Deficiencies" has been added as a standing agenda item for this committee. The EOC and Safety Committee minutes will be forwarded monthly for six months to Quality Management Service to monitor that there is a standing agenda item for the survey deficiencies and related deficiencies are being tracked to completion. This monitoring will continue for six months to assure consistent discussion and action tracking of these items has been established. The monitor results will be reported monthly to the Administrative Executive Board.

Recommendation 8. We recommended that processes be strengthened to ensure that all non-HPC staff receive end-of-life training.

Concur

Target date for completion: September 30, 2013

The Training program for non-HPC care staff has been strengthened by assigning mandatory end of life training to all non-HPC staff who provide or have potential to provide direct patient care to our Hospice and Palliative Care patients. This will include psychologists, physicians, nurses, social workers, and chaplains. The TMS training will be reported monthly for six months in the Geriatric and Extended Care Council and quarterly for two quarters to the Clinical Executive Board. After this monitoring periodic random monitoring will occur to assure new staff are trained.

Recommendation 9. We recommended that a process be established to track HPC consults that are not acted upon within the requested timeframe.

Concur

Target date for completion: September 30, 2013

All Hospice and Palliative care consults will be tracked on a weekly basis. A report will be generated for consults that have not been acted upon within the required seven day time period. This list will be forwarded to the supervisory clerks in PBS, the providers and the associated administrative staff. The PBS staff will then give these consults priority for scheduling. The HPC team will monitor and track for six months all consults not scheduled within the required seven days. This monitor will be reported monthly for six months in the Geriatric and Extended Care Council and quarterly for two quarters in the Clinical Executive Board.

Recommendation 10. We recommended that processes be strengthened to ensure that HPC inpatients' pain is consistently assessed and results documented in EHRs and that compliance be monitored.

Concur

Target date for completion: September 30, 2013

All Dayton VA Hospice and Palliative Care Nurses will participate in a "Pain Summit" by March 31, 2013. The Pain Summit will include a review and training of MCP 117-08 "Pain Management Program" including clear direction regarding pain assessments and documentation. The Hospice Charge Nurses will monitor for six months for compliance of pain assessment and documentation by initiating BCMA PRN effectiveness reports twice on all shifts. The Charge Nurse will take appropriate action based on the reports to assure the pain assessments are accomplished and documented according to policy. The Hospice Charge Nurses will submit all PRN effectiveness reports to the Hospice Nurse Manager for review daily. The Hospice Nurse Manager will provide weekly reports to the Community Living Center, Chief Nurse during the Nurse Manager meeting. The Hospice Nurse Manger will provide remedial training and take appropriate action if needed for exceptions. The monitor results will be reported monthly for six months to the Extended Care Quality Council and Care Excellence Council.

Recommendation 11. We recommended that managers initiate protected peer review for the three identified patients and complete any recommended review actions.

Concur

Target date for completion: June 30, 2013

Initial peer reviews for the three identified patients have been completed. The cases are scheduled to be presented to the Peer Review Committee on April 4, 2013. Peer Review Committee determinations and recommendations will be shared when finalized.

OIG Contact and Staff Acknowledgments

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Luke Messer, Michael Turner

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Endnotes

¹ References used for this topic included:

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² References used for this topic included:

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- VA Handbook 0730, *Security and Law Enforcement*, August 11, 2000.
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⁵ References used for this topic were:

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⁶ The references used for this topic were:

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⁷ The reference used for this topic was:

- VHA Office of Analytics and Business Intelligence, *External Peer Review Technical Manual*, FY2012 quarter 4, June 15, 2012, p. 80-98.