Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 15-00625-37

Combined Assessment Program Review of the VA Southern Nevada Healthcare System North Las Vegas, Nevada

November 24, 2015

Washington, DC 20420

To Report Suspected Wrongdoing in VA Programs and Operations
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Glossary

AD	advance directive
CAP	Combined Assessment Program
CT	computed tomography
EAM	emergency airway management
EHR	electronic health record
EOC	environment of care
facility	VA Southern Nevada Healthcare System
FY	fiscal year
MH	mental health
NA	not applicable
NM	not met
OIG	Office of Inspector General
QM	quality management
SCI	spinal cord injury
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 September 14, 2015.

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

- Computed Tomography Radiation Monitoring

The facility's reported accomplishments were employee engagement efforts to improve communication, several quality and continuous improvement activities, and an emergency preparedness exercise.

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

Quality Management: Require that licensed independent practitioners who perform emergency airway management receive the appropriate training. Ensure licensed independent practitioners' folders do not contain non-allowed information.

Environment of Care: Consistently document discussion of environment of care rounds deficiencies and specifics in Environment of Care Committee meeting minutes. Monitor the use of clean biohazard bags. Ensure designated employees receive emergency evacuation device training and competency assessment, and revise the local policy to define expectations for competency assessment.

Medication Management: Use special medication labeling for look-alike and sound-alike medications. Ensure oral syringes are available for liquid medications in the Emergency Department and on the intensive care-step down unit, and store them separately from parenteral syringes.

Coordination of Care: Ensure requestors consistently select the proper consult title.

Advance Directives: Revise the local policy to address advance directive notification, screening, and discussions. Screen inpatients to determine whether they have advance directives, and document the screening. Ask inpatients whether they would like to discuss creating, changing, and/or revoking advance directives.

Surgical Complexity: Revise Radiology Service policies to require a 30-minute on-call reporting time for computed tomography scans and a 30-minute on-call response time for radiology interpretation.

Emergency Airway Management: Ensure clinicians complete all required emergency airway management competency reassessment elements prior to providing coverage. Require appropriate emergency airway management coverage during all hours the facility provides patient care.

Follow-Up on Medication Management Issue: Correct identified deficiencies from the annual pharmacy physical security survey.

Comments

The Veterans Integrated Service Network Director and Acting Facility Director agreed with the Combined Assessment Program review findings and recommendations and provided acceptable improvement plans. (See Appendixes C and D, pages 27–34, 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
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Objectives and Scope

Objectives

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

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

Scope

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

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

- QM
- EOC
- Medication Management
- Coordination of Care
- CT Radiation Monitoring
- ADs
- Surgical Complexity
- EAM
- Follow-Up on Medication Management Issue

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

The review covered facility operations for FY 2014 and FY 2015 through September 18, 2015, and inspectors conducted the review in accordance with OIG standard operating procedures for CAP reviews. We also asked the facility to provide the status on the recommendations we made in our previous CAP report (*Combined Assessment Program Review of the VA Southern Nevada Healthcare System, Las Vegas, Nevada,* Report No. 13-00888-203, May 30, 2013). We made a repeat recommendation in medication management.

During this review, we presented crime awareness briefings for 174 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. We distributed an electronic survey to all facility employees and received 473 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 the OIG to monitor until the facility implements corrective actions.

Reported Accomplishments

Employee Engagement Efforts

In an effort to engage employees throughout all levels of the organization, the facility initiated activities to improve communication. These included:

- Director's weekly e-mail message to employees, which also recognizes employees identified by veterans and stakeholders for demonstrating VA's core values.
- New employee orientation program expansion, which received an outstanding rating from more than 88 percent of attendees.
- Supervisory staff retreat and training to help identify and address challenges and barriers from the FY 2014 All Employee Survey.
- Imaging Service's "open door meetings" to discuss ideas to improve work practices and provide better patient care.

Quality and Continuous Improvement Activities

In FY 2015, the facility embraced continuous quality and performance improvement culture by implementing safe, patient-centered improvement efforts such as:

- A nursing employee on-call tour during the hours of 9:00 a.m. to 5:30 p.m., which helped reduce employee fatigue and overtime costs by $13,400.
- A sharps safety zones utilization project that resulted in the facility being bloodborne pathogen exposure free from sharps injuries.

- A successful collaboration between the Emergency Department and Radiology Service, which resulted in better CT coverage and reduced wait time for CT scans.
- Telephone responsiveness initiatives that reduced the average time to answer calls from 2 minutes to 1.16 minutes and the call abandonment rate from 18.5 to 9.1 percent by hiring more pharmacy technicians to handle large volume pharmacy calls, monitoring the time call center employees were off the phone, and tracking the purpose of each call.

Emergency Preparedness – Point of Dispensing Exercise

In 2015, Nursing Service, in collaboration with the facility's Emergency Management Team, planned and responded to a community Ebola preparedness training exercise to protect critical employees and others in the event of a potential exposure to an infectious agent.

The facility then developed the *All Hazards Emergency Cache* and processed 83 percent of its workforce through a Point of Dispensing[1] exercise. During the exercise, the facility provided employee education and influenza vaccinations to employees and veterans. A facility work group identified and secured proper personal protective equipment, developed and provided training on personal protective equipment, and presented awareness training to employees on how to manage a potential exposure. Information was posted throughout the facility and included a public awareness campaign for patients.

[1] A Point of Dispensing site is a place where vaccines, antibiotics, and other medications or supplies can be quickly dispensed to a large number of people during public health events or emergencies. A Point of Dispensing site may be opened to prevent exposure to an infectious disease or treat an infectious disease outbreak.

Results and Recommendations

QM

The purpose of this review was to determine whether facility senior managers actively supported and appropriately responded to QM efforts and whether the facility met selected requirements within its QM program.[a]

We conversed with senior managers and key QM employees, and we evaluated meeting minutes, 18 credentialing and privileging folders, and other relevant documents. The table below shows the areas reviewed for this topic. The area marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

NM	Areas Reviewed	Findings	Recommendations
	There was a senior-level committee responsible for key quality, safety, and value functions that met at least quarterly and was chaired or co-chaired by the Facility Director. • The committee routinely reviewed aggregated data. • QM, patient safety, and systems redesign appeared to be integrated.		
	Peer reviewed deaths met selected requirements: • Peers completed reviews within specified timeframes. • The Peer Review Committee reviewed cases receiving initial Level 2 or 3 ratings. • Involved providers were invited to provide input prior to the final Peer Review Committee determination.		

NM	Areas Reviewed (continued)	Findings	Recommendations
X	Credentialing and privileging processes met selected requirements: • Facility managers reviewed privilege forms annually and ensured proper approval of revised forms. • Facility managers ensured appropriate privileges for licensed independent practitioners. • Facility managers removed licensed independent practitioners' access to patients' EHRs upon separation. • Facility managers properly maintained licensed independent practitioners' folders.	• None of the 18 licensed independent practitioners whose folders we reviewed met the EAM training requirements. • Fourteen of the 18 licensed independent practitioners' folders contained non-allowed information.	**1.** We recommended that facility managers ensure that licensed independent practitioners who perform emergency airway management receive the appropriate training. **2.** We recommended that the facility ensure that licensed independent practitioners' folders do not contain non-allowed information.
	Observation bed use met selected requirements: • The facility gathered data regarding appropriateness of observation bed usage. • The facility reassessed observation criteria and/or utilization if conversions to acute admissions were consistently 25–30 percent or more.		
	The process to review resuscitation events met selected requirements: • An interdisciplinary committee reviewed episodes of care where resuscitation was attempted. • Resuscitation event reviews included screening for clinical issues prior to events that may have contributed to the occurrence of the code. • The facility collected data that measured performance in responding to events.		

NM	Areas Reviewed (continued)	Findings	Recommendations
	The surgical review process met selected requirements: • An interdisciplinary committee with appropriate leadership and clinical membership met monthly to review surgical processes and outcomes. • The Surgical Work Group reviewed surgical deaths with identified problems or opportunities for improvement. • The Surgical Work Group reviewed additional data elements.		
	Clinicians appropriately reported critical incidents.		
	The safe patient handling program met selected requirements: • A committee provided program oversight. • The committee gathered, tracked, and shared patient handling injury data.		
	The process to review the quality of entries in the EHR met selected requirements: • A committee reviewed EHR quality. • A committee analyzed data at least quarterly. • Reviews included data from most services and program areas.		
	The policy for scanning internal forms into EHRs included the following required items: • Quality of the source document and an alternative means of capturing data when the quality of the document is inadequate. • A correction process if scanned items have errors.		

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

EOC

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

We inspected the intensive care and locked MH units, two medical/surgical (6E and 6W) units, and the Emergency Department. Additionally, we reviewed relevant documents, including 10 employee training and competency records, and conversed with key employees and managers. The table below shows the areas reviewed for this topic. The areas marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

NM	Areas Reviewed for General EOC	Findings	Recommendations
X	EOC Committee minutes reflected sufficient detail regarding identified deficiencies, corrective actions taken, and tracking of corrective actions to closure for the facility and the community based outpatient clinics.	Six months of EOC Committee meeting minutes reviewed: • January and April minutes did not include specifics about EOC rounds deficiencies and only included the number of deficiencies, number closed, and number open. • February, March, May, and June minutes did not include any discussion regarding EOC rounds deficiencies.	**3.** We recommended that Environment of Care Committee meeting minutes consistently document discussion of environment of care rounds deficiencies and specifics, including the deficiency, location, action, and resolution and any trends.
	The facility conducted an infection prevention risk assessment.		
	Infection Prevention/Control Committee minutes documented discussion of identified high-risk areas, actions implemented to address those areas, and follow-up on implemented actions and included analysis of surveillance activities and data.		
	The facility had established a process for cleaning equipment.		
	The facility conducted required fire drills in buildings designated for health care occupancy and documented drill critiques.		

NM	Areas Reviewed for General EOC (continued)	Findings	Recommendations
	The facility had a policy/procedure/guideline for identification of individuals entering the facility, and units/areas complied with requirements.		
	The facility met fire safety requirements.		
	The facility met environmental safety requirements.		
	The facility met infection prevention requirements.		
	The facility met medication safety and security requirements.		
	The facility met privacy requirements.		
X	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.	Occupational Safety and Health Administration regulations reviewed, which require that only biohazard materials are to be placed or stored in biohazard bags. • Three of five patient care areas used clean biohazard plastic bags to hold patient medications or cables.	**4.** We recommended that facility managers monitor the use of clean biohazard bags to ensure they are used appropriately.
	Areas Reviewed for SCI Center		
NA	The facility completed and documented required inspection checklists of all ceiling mounted patient lifts.		
NA	The facility met fire safety requirements in the SCI Center.		
NA	The facility met environmental safety requirements in the SCI Center.		
NA	The facility met infection prevention requirements in the SCI Center.		
NA	The facility met medication safety and security requirements in the SCI Center.		
NA	The facility met patient privacy requirements in the SCI Center.		

NM	Areas Reviewed for SCI Center (continued)	Findings	Recommendations
NA	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.		
	Areas Reviewed for Emergency Management		
	The facility had a documented Hazard Vulnerability Assessment and reviewed the assessment annually.		
	The facility maintained a list of resources and assets it may need during an emergency.		
	The facility had a written Emergency Operations Plan that addressed key components.		
	The facility had a written description of how it will respond to an influx of potentially infectious patients and a plan for managing them over an extended period of time.		
X	Employees received training and competency assessment on use of emergency evacuation devices.	• Three of 10 employees did not have documented evidence of emergency evacuation device training during the past 12 months. • Seven of 10 employees did not have documented evidence of emergency evacuation device competency assessment during the past 12 months. • Local policy did not define expectations for routine competency assessment.	**5.** We recommended that facility managers ensure designated employees receive emergency evacuation device training and competency assessment and revise the local policy to define expectations for competency assessment.
	Evacuation devices were immediately accessible and in good repair.		
	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.		

NM	Areas Reviewed for Construction Safety	Findings	Recommendations
NA	The facility met selected dust control, temporary barrier, storage, and security requirements for the construction site perimeter.		
NA	The facility complied with any additional elements required by VHA or local policy, or other regulatory standards.		

Medication Management

The purpose of this review was to determine whether the facility had established safe medication storage practices in accordance with VHA policy and Joint Commission standards.[c]

We reviewed relevant documents, the training records of 20 nursing employees, and pharmacy monthly medication storage area inspection documentation for the past 6 months. Additionally, we inspected one medical unit, the post-anesthesia care unit, the intensive care-step down unit, and the Emergency Department and for these areas reviewed documentation of narcotic wastage from automated dispensing machines and inspected crash carts containing emergency medications. The table below shows the areas reviewed for this topic. The areas marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

NM	Areas Reviewed	Findings	Recommendations
	Facility policy addressed medication receipt in patient care areas, storage procedures until administration, and staff authorized to have access to medications and areas used to store them.		
	The facility required two signatures on controlled substances partial dose wasting.		
	The facility defined those medications and supplies needed for emergencies and procedures for crash cart checks, checks included all required elements, and the facility conducted checks with the frequency required by local policy.		
	The facility prohibited storage of potassium chloride vials in patient care areas.		
NA	If the facility stocked heparin in concentrations of more than 5,000 units per milliliter in patient care areas, the Chief of Pharmacy approved it.		

NM	Areas Reviewed (continued)	Findings	Recommendations
X	The facility maintained a list of the look-alike and sound-alike medications it stores, dispenses, and administers; reviewed this list annually and ensured it was available for staff reference; and had labeling/storage processes to prevent errors.	• The facility did not use special medication labeling for look-alike and sound-alike medications.	**6.** We recommended that the facility use special medication labeling for look-alike and sound-alike medications and that facility managers monitor compliance.
	The facility identified in writing its high-alert and hazardous medications, ensured the high-alert list was available for staff reference, and had processes to manage these medications.		
	The facility conducted and documented inspections of all medication storage areas at least monthly, fully implemented corrective actions, and monitored the changes.		
	The facility/Pharmacy Service had a written policy for safe use of automated dispensing machines that included oversight of overrides and employee training and minimum competency requirements for users, and employees received training or competency assessment in accordance with local policy.		
X	The facility employed practices to prevent wrong-route drug errors.	• In the Emergency Department and on the intensive care-step down unit, employees reported using parenteral syringes for oral liquid medications.	**7.** We recommended that facility managers ensure that oral syringes are available for liquid medications in the Emergency Department and on the intensive care-step down unit and that they are stored separately from parenteral syringes to minimize the risk of wrong-route medication errors.

NM	Areas Reviewed (continued)	Findings	Recommendations
	Medications prepared but not immediately administered contained labels with all required elements.		
	The facility removed medications awaiting destruction or stored them separately from medications available for administration.		
	The facility met multi-dose insulin pen requirements.		
	The facility complied with any additional elements required by VHA or local policy.		

Coordination of Care

The purpose of this review was to evaluate the consult management process and the completion of inpatient clinical consults.[d]

We reviewed relevant documents, and we conversed with key employees. Additionally, we reviewed the EHRs of 42 randomly selected patients who had a consult requested during an acute care admission from January 1 through June 30, 2014. The table below shows the areas reviewed for this topic. The area marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

NM	Areas Reviewed	Findings	Recommendations
	A committee oversaw the facility's consult management processes.		
	Major bed services had designated employees to: • Provide training in the use of the computerized consult package • Review and manage consults		
	Consult requests met selected requirements: • Requestors included the reason for the consult. • Requestors selected the proper consult title. • Consultants appropriately changed consult statuses, linked responses to the requests, and completed consults within the specified timeframe.	• Seven consult requests (17 percent) did not include "inpatient" in the title.	**8.** We recommended that requestors consistently select the proper consult title and that facility managers monitor compliance.
	The facility met any additional elements required by VHA or local policy.		

CT Radiation Monitoring

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

We reviewed relevant documents, including qualifications and dosimetry monitoring for seven CT technologists and two CT scanner inspection reports, and conversed with key managers and employees. We also reviewed the EHRs of 48 randomly selected patients who had a CT scan January 1–December 31, 2014. The table below shows the areas reviewed for this topic. Any items that did not apply to this facility are marked NA. The facility generally met requirements. We made no recommendations.

NM	Areas Reviewed	Findings	Recommendations
	The facility had a designated Radiation Safety Officer responsible for oversight of the radiation safety program.		
	The facility had a CT/imaging/radiation safety policy or procedure that included: • A CT quality control program with program monitoring by a medical physicist at least annually, image quality monitoring, and CT scanner maintenance • CT protocol monitoring to ensure doses were as low as reasonably achievable and a method for identifying and reporting excessive CT patient doses to the Radiation Safety Officer • A process for managing/reviewing CT protocols and procedures to follow when revising protocols • Radiologist review of appropriateness of CT orders and specification of protocol prior to scans		
	A radiologist and technologist expert in CT reviewed all CT protocols revised during the past 12 months.		

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

ADs

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

We reviewed relevant documents and conversed with key employees. Additionally, we reviewed the EHRs of 50 randomly selected patients who had an acute care admission January 1–December 31, 2014. The table below shows the areas reviewed for this topic. The areas marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

NM	Areas Reviewed	Findings	Recommendations
X	The facility had an AD policy that addressed: • AD notification, screening, and discussions • Proper use of AD note titles	• Facility policy did not address AD notification, screening, and discussions.	**9.** We recommended that the facility revise the local policy to address advance directive notification, screening, and discussions.
X	Employees screened inpatients to determine whether they had ADs and used appropriate note titles to document screening.	• Ten of the 50 EHRs (20 percent) did not contain documentation that employees screened inpatients to determine whether they had ADs.	**10.** We recommended that employees screen inpatients to determine whether they have advance directives and document the screening and that facility managers monitor compliance.
	When patients provided copies of their current ADs, employees had scanned them into the EHR. • Employees correctly posted patients' AD status.		
X	Employees asked inpatients if they would like to discuss creating, changing, and/or revoking ADs. • When inpatients requested a discussion, employees documented the discussion and used the required AD note titles.	• Seven of the 40 applicable EHRs (18 percent) did not contain documentation that employees asked inpatients whether they wished to discuss creating, changing, and/or revoking ADs.	**11.** We recommended that employees ask inpatients whether they would like to discuss creating, changing, and/or revoking advance directives and that facility managers monitor compliance.
	The facility met any additional elements required by VHA or local policy.		

Surgical Complexity

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

We reviewed relevant documents and the training records of 10 employees, and we conversed with key managers and employees. The table below shows the areas reviewed for this topic. The area marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

NM	Areas Reviewed	Findings	Recommendations
X	Facility policy defined appropriate availability for all support services required by VHA for the facility's surgical designation.	Radiology Service's policies did not clearly specify that: • Employees on call for CT scans must report within 30 minutes. • Radiology interpretation on-call response must be within 30 minutes.	**12.** We recommended that Radiology Service revise its policies to require a 30-minute on-call reporting time for computed tomography scans and a 30-minute on-call response time for radiology interpretation.
	Employees providing selected tests and patient care after operational hours had appropriate competency assessments and validation.		
	The facility properly reported surgical procedures performed that were beyond the facility's surgical complexity designation. • The facility reviewed and implemented recommendations made by the VISN Chief Surgical Consultant.		
	The facility complied with any additional elements required by VHA or local policy.		

EAM

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

We reviewed relevant documents, including competency assessment document of 18 clinicians applicable for the review period January 1–June 30, 2014, and the EAM coverage schedule for 30 selected dates from this same timeframe, and we conversed with key managers and employees. The table below shows the areas reviewed for this topic. The areas marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

NM	Areas Reviewed	Findings	Recommendations
	The facility had a local EAM policy or had a documented exemption.		
NA	If the facility had an exemption, it did not have employees privileged to perform procedures using moderate or deep sedation that might lead to airway compromise.		
	Facility policy designated a clinical subject matter expert, such as the Chief of Staff or Chief of Anesthesia, to oversee EAM.		
	Facility policy addressed key VHA requirements, including: • Competency assessment and reassessment processes • Use of equipment to confirm proper placement of breathing tubes • A plan for managing a difficult airway		
NA	Initial competency assessment for EAM included: • Subject matter content elements and completion of a written test • Successful demonstration of procedural skills on airway simulators or mannequins • Successful demonstration of procedural skills on patients		

NM	Areas Reviewed (continued)	Findings	Recommendations
X	Reassessments for continued EAM competency were completed at the time of renewal of privileges or scope of practice and included: • Review of clinician-specific EAM data • Subject matter content elements and completion of a written test • Successful demonstration of procedural skills on airway simulators or mannequins • At least one occurrence of successful airway management and intubation in the preceding 2 years, written certification of competency by the supervisor, or successful demonstration of skills to the subject matter expert • A statement related to EAM if the clinician was not a licensed independent practitioner	• None of the 18 clinicians had documentation of completion of all required elements prior to providing EAM coverage.	**13.** We recommended that the facility ensure clinicians complete all required emergency airway management competency reassessment elements prior to providing emergency airway management coverage and that facility managers monitor compliance.
X	The facility had a clinician with EAM privileges or scope of practice or an anesthesiology staff member available during all hours the facility provided patient care.	• For 4 of the 30 (13 percent) randomly selected days, the facility did not have appropriate EAM coverage.	**14.** We recommended that the facility have appropriate emergency airway management coverage during all hours the facility provides patient care and that facility managers monitor compliance.
	Video equipment to confirm proper placement of breathing tubes was available for immediate clinician use.		
	The facility complied with any additional elements required by VHA or local policy.		

Review Activity With Previous CAP Recommendations

Follow-Up on Medication Management Issue

As a follow-up to a recommendation from our prior CAP review, we reassessed facility compliance with correcting annual physical security survey findings in the pharmacy area.[i]

Pharmacy Annual Physical Security Survey. During our previous CAP review, we identified that deficiencies from the 2012 physical security survey were not corrected. During this review, we found that the previously identified deficiencies remained unresolved.

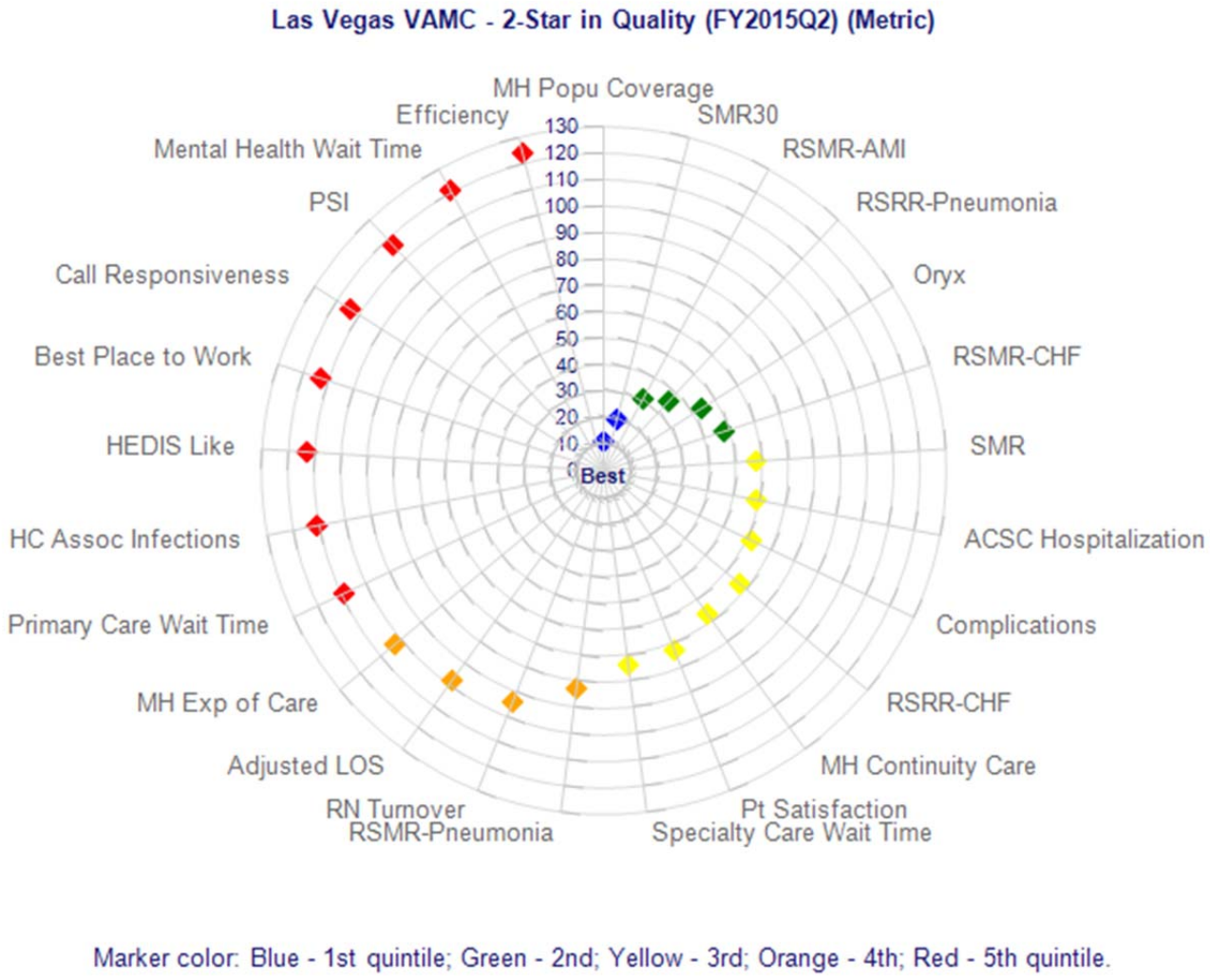
Recommendation

15. We recommended that facility managers ensure that identified deficiencies from the annual pharmacy physical security survey are corrected and monitor compliance.

Facility Profile (Las Vegas/593) FY 2015 through September 2015[2]	
Type of Organization	Secondary
Complexity Level	1c-High complexity
Affiliated/Non-Affiliated	Affiliated
Total Medical Care Budget in Millions as of August 2015	$455.9
Number of:	
• **Unique Patients**	57,375
• **Outpatient Visits**	797,848
• **Unique Employees**[3]	1,898
Type and Number of Operating Beds:	
• **Hospital**	90
• **Community Living Center**	0
• **MH**	20
Average Daily Census:	
• **Hospital**	64
• **Community Living Center**	0
• **MH**	17
Number of Community Based Outpatient Clinics	5
Location(s)/Station Number(s)	Pahrump/593GC Northwest/593GD Southeast/593GE Southwest/593GF Northeast/593GG
VISN Number	21

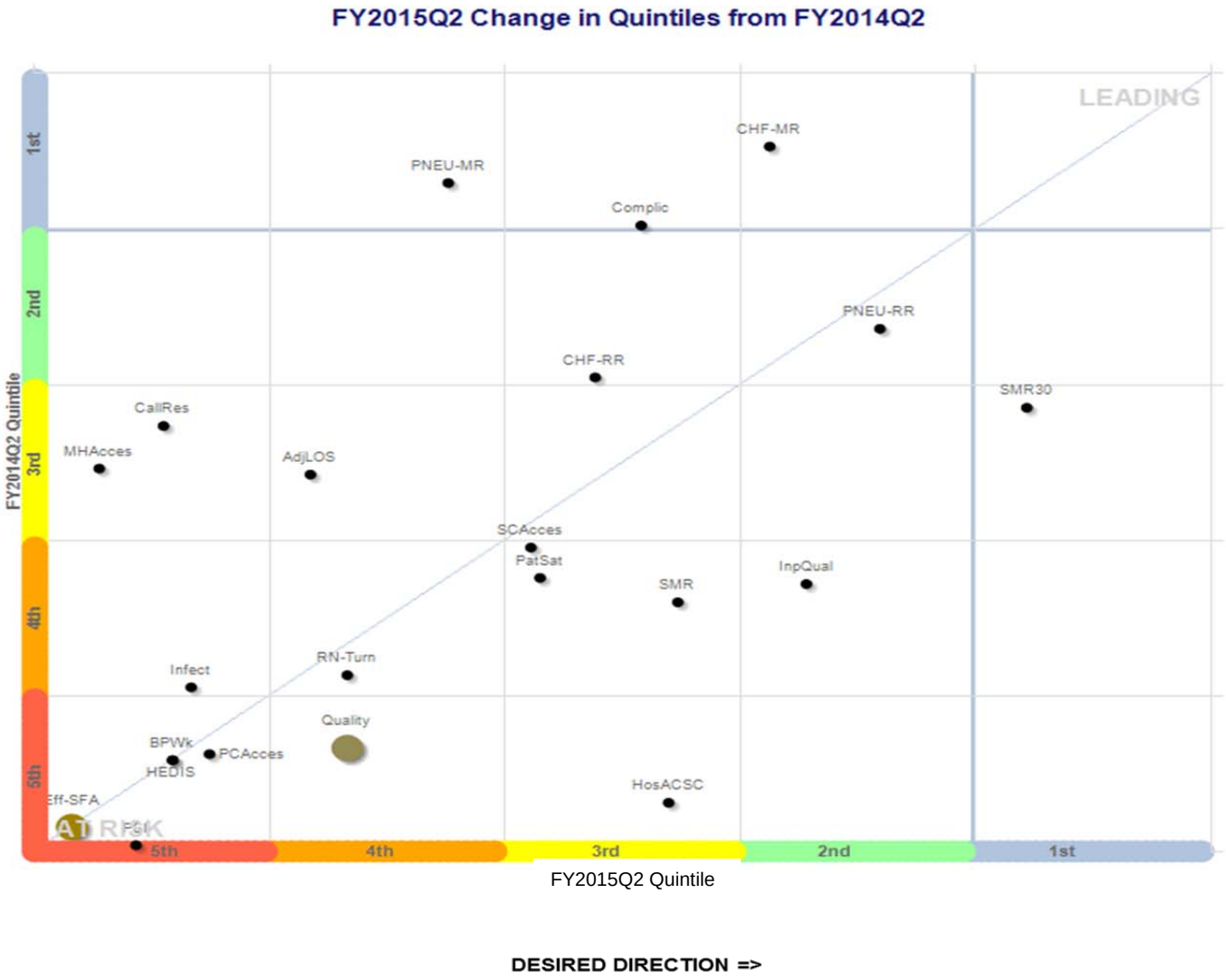
[2] All data is for FY 2015 through September 2015 except where noted.
[3] Unique employees involved in direct medical care (cost center 8200).

Strategic Analytics for Improvement and Learning (SAIL)[4]



[4] Metric definitions follow the graphs.

Scatter Chart



NOTE

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

Metric Definitions

Measure	Definition	Desired direction
ACSC Hospitalization	Ambulatory care sensitive condition hospitalizations (observed to expected ratio)	A lower value is better than a higher value
Adjusted LOS	Acute care risk adjusted length of stay	A lower value is better than a higher value
Best Place to Work	Overall satisfaction with job	A higher value is better than a lower value
Call Center Responsiveness	Average speed of call center responded to calls in seconds	A lower value is better than a higher value
Call Responsiveness	Call center speed in picking up calls and telephone abandonment rate	A lower value is better than a higher value
Complications	Acute care risk adjusted complication ratio	A lower value is better than a higher value
Efficiency	Overall efficiency measured as 1 divided by SFA (Stochastic Frontier Analysis)	A higher value is better than a lower value
Employee Satisfaction	Overall satisfaction with job	A higher value is better than a lower value
HC Assoc Infections	Health care associated infections	A lower value is better than a higher value
HEDIS	Outpatient performance measure (HEDIS)	A higher value is better than a lower value
MH Wait Time	MH wait time for new and established patients (top 50 clinics; FY13 and later)	A higher value is better than a lower value
MH Continuity Care	MH continuity of care (FY14Q3 and later)	MH Continuity Care
MH Exp of Care	MH experience of care (FY14Q3 and later)	A higher value is better than a lower value
MH Popu Coverage	MH population coverage (FY14Q3 and later)	A higher value is better than a lower value
Oryx	Inpatient performance measure (ORYX)	A higher value is better than a lower value
Primary Care Wait Time	Primary care wait time for new and established patients (top 50 clinics; FY13 and later)	A higher value is better than a lower value
PSI	Patient safety indicator (observed to expected ratio)	A lower value is better than a higher value
Pt Satisfaction	Overall rating of hospital stay (inpatient only)	A higher value is better than a lower value
RN Turnover	Registered nurse turnover rate	A lower value is better than a higher value
RSMR-AMI	30-day risk standardized mortality rate for acute myocardial infarction	A lower value is better than a higher value
RSMR-CHF	30-day risk standardized mortality rate for congestive heart failure	A lower value is better than a higher value
RSMR-Pneumonia	30-day risk standardized mortality rate for pneumonia	A lower value is better than a higher value
RSRR-AMI	30-day risk standardized readmission rate for acute myocardial infarction	A lower value is better than a higher value
RSRR-CHF	30-day risk standardized readmission rate for congestive heart failure	A lower value is better than a higher value
RSRR-Pneumonia	30-day risk standardized readmission rate for pneumonia	A lower value is better than a higher value
SMR	Acute care in-hospital standardized mortality ratio	A lower value is better than a higher value
SMR30	Acute care 30-day standardized mortality ratio	A lower value is better than a higher value
Specialty Care Wait Time	Specialty care wait time for new and established patients (top 50 clinics; FY13 and later)	A higher value is better than a lower value

VISN Director Comments

Department of Veterans Affairs

Memorandum

Date: November 6, 2015

From: Director, VA Sierra Pacific Network (10N21)

Subject: **CAP Review of the VA Southern Nevada Healthcare System, North Las Vegas, NV**

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

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

1. Thank you for the opportunity to review the draft report from the recent OIG CAP site visit at the Las Vegas facility. I concur with the attached action plan developed by the facility.

2. Should you have any questions regarding the plan, please contact Terry Sanders, Associate Quality Manager for VISN 21 at (707) 562-8350.

Sheila M. Cullen

Attachments

Acting Facility Director Comments

Department of Veterans Affairs

Memorandum

Date: November 4, 2015

From: Acting Director, VA Southern Nevada Healthcare System (593/00)

Subject: **CAP Review of the VA Southern Nevada Healthcare System, North Las Vegas, NV**

To: Director, VA Sierra Pacific Network (10N21)

1. We appreciate the opportunity to review the draft report of recommendations resulting from the OIG CAP site visit conducted at VA Southern Nevada Healthcare System the week of September 14th.

2. Please find attached the response to each recommendation. We have completed or are in the process of completing the actions to address the recommendations. Monitoring will continue until compliance has been ensured.

William Caron, Acting Director

Comments to OIG's Report

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

OIG Recommendations

Recommendation 1. We recommended that facility managers ensure that licensed independent practitioners who perform emergency airway management receive the appropriate training.

Concur

Target date for completion: January 31, 2016

Facility response: The Chief of Anesthesiology will continue to implement the current process for emergency airway management skills verification and competency assessment as outlined in the facility policy. Upon completion of training, competency checklists and skills verification documents will be provided to the Service Chief of Acute Medicine/Emergency Department. The Chief of Acute Medicine will ensure that all Emergency Department providers and all respiratory therapists complete the training by 12/31/2015. Staff will only be scheduled for out of operating room airway management (OOORAM) coverage when all training requirements have been met and documented with final approval by the Chief of Anesthesiology.

The Chief of Acute Medicine and/or designee will monitor and document completion of training by required staff (ED providers and respiratory therapists) monthly using the OOORAM tracking spreadsheet. Status of training will be reported to CPR Committee, the Medical Executive Board, and the Organizational Excellence Leadership Board.

Recommendation 2. We recommended that the facility ensure that licensed independent practitioners' folders do not contain non-allowed information.

Concur

Target date for completion: January 31, 2016

Facility response: The Medical Staff office completed the removal of training certificates from all 2-part credentialing folders on 9/16/2015. The supervisor will audit the folder of all new providers to ensure 90% compliance with this requirement is maintained for three months consecutively. Results will be reported to the Medical Executive Board and the Organizational Excellence Leadership Board.

Recommendation 3. We recommended that Environment of Care Committee meeting minutes consistently document discussion of environment of care rounds deficiencies and specifics, including the deficiency, location, action, and resolution and any trends.

Concur

Target date for completion: January 31, 2016

Facility response: The Environment of Care Committee (EOCC) membership will ensure the meeting minutes reflect specific information regarding EOC deficiencies such as types, locations, resolutions and trends. The recorder will ensure items that have been determined by the EOCC membership to require further action remain open in the meeting minutes until instructed by the membership that the item can be closed. EOCC membership will review the minutes monthly for completeness & accuracy. The EOCC meeting minutes are forwarded to the Executive Leadership (PENTAD) each month for review and signature.

Recommendation 4. We recommended that facility managers monitor the use of clean biohazard bags to ensure they are used appropriately.

Concur

Target date for completion: December 31, 2015

Facility response: An email was immediately sent to all nursing staff with instructions that biohazard bags should be used to transport, dispose of, or store until pickup biohazards only. A subsequent inspection of all inpatient units resulted in no further observation of inappropriate use of biohazard bags. Education of all inpatient unit nursing staff will be reinforced by the Infection Control Consultants during the next staff meeting. Observation for inappropriate use of biohazard bags will be monitored during Infection Control tracers until 90% compliance is sustained for three consecutive months. Results will be reported to the Infection Control Committee and the Organizational Excellence Leadership Board.

Recommendation 5. We recommended that facility managers ensure designated employees receive emergency evacuation device training and competency assessment and revise the local policy to define expectations for competency assessment.

Concur

Target date for completion: June 30, 2016

Facility response: The local policy will be revised to define the expectations for receiving emergency evacuation device training and competency assessment by 11/30/2015. Unit Peer Leaders (UPL), in-patient and outpatient clinical staff have been designated to receive emergency evacuation device training and competency assessment. UPL training will be completed by 4/30/2016. The remainder of the inpatient and outpatient clinical staff will be trained by 6/30/2016. UPL and evacuation

device training will be offered a minimum of twice a year thereafter. Designated staff will be required to complete annual training appropriate for their role during the clinical area annual Skills Fair. The Safe Patient Handling Subcommittee will monitor compliance until the target of 90% compliance is sustained for three consecutive months. Results will be reported to Environment of Care Committee and the Organizational Excellence Leadership Board.

Recommendation 6. We recommended that the facility use special medication labeling for look-alike and sound-alike medications and that facility managers monitor compliance.

Concur

Target date for completion: January 31, 2016

Facility response: The drawers in the PYXIS cabinets that contain the look-alike and sound-alike (LASA) medications are labeled when any LASA medication is loaded. Compliance will be monitored during monthly ward medication inspections by Pharmacy Service and Quality Management tracers until 90% compliance is sustained for three consecutive months. The results will be reported to the Pharmacy and Therapeutics Committee and the Organizational Excellence Leadership Board.

Recommendation 7. We recommended that facility managers ensure that oral syringes are available for liquid medications in the Emergency Department and on the intensive care-step down unit and that they are stored separately from parenteral syringes to minimize the risk of wrong-route medication errors.

Concur

Target date for completion: February 29, 2016

Facility response: Logistics had supplied oral syringes and clearly identified/labeled all parenteral syringes as “IV use only” by 10/31/2015. Nursing managers will provide education regarding the appropriate use of oral and parenteral syringes during medication administration by 11/30/2015. The information was/will be also included in the Nursing Professional Service newsletter in October and November 2015. Monitoring will be take place during Quality Management tracers in the Emergency Department and on all inpatient units to include the intensive care-step down unit until 90% compliance is sustained for three months. The results will be reported to the Pharmacy and Therapeutics Committee and the Organizational Excellence Leadership Board.

Recommendation 8. We recommended that requestors consistently select the proper consult title and that facility managers monitor compliance.

Concur

Target date for completion: December 31, 2015

Facility response: Note: The records audited by the OIG team included records with documentation that occurred prior to implementing/completing the following actions. The Consult Committee reviewed all inpatient consult templates in January 2015 to ensure all services providing consultations had a consult title that included the word inpatient, all links under inpatient consults on the consult menu pointed to the proper consult and all inpatient consults were represented on the menu. All inpatient consultation templates for services providing consultation are current and available to providers. This process will be ongoing for all new inpatient consults added to the menu. The most recent audit of >70 inpatient consultations demonstrated 100% compliance with the proper use of "inpatient" consult title had been achieved. Audits will continue until 90% compliance is sustained for three consecutive months. Results will be reported to the Consult Management Committee and the Organizational Excellence Leadership Board.

Recommendation 9. We recommended that the facility revise the local policy to address advance directive notification, screening, and discussions.

Concur

Target date for completion: January 31, 2016

Facility response: The local policy will be revised by the Advance Directive Workgroup to include the requirements for addressing and documenting advance directive notification, screening, and discussions. The policy will be forwarded to the Executive Leadership (PENTAD) for review and final approval by 1/31/16.

Recommendation 10. We recommended that employees screen inpatients to determine whether they have advance directives and document the screening and that facility managers monitor compliance.

Concur

Target date for completion: April 30, 2016

Facility response: Chief, Acute Medicine and the Associate Nurse Executive, Inpatient will ensure all inpatient staff (licensed independent practitioners, nursing staff, and social work) are re-educated on the requirements for Advance Directive screening of patients admitted to the facility and the documentation of discussions (creating, changing, and/or revoking advance directives) using appropriate note titles. Monitoring will occur until the target of 90% compliance is sustained for three consecutive months. Results will be reported to Quality Management and the Organizational Excellence Leadership Board.

Recommendation 11. We recommended that employees ask inpatients whether they would like to discuss creating, changing, and/or revoking advance directives and that facility managers monitor compliance.

Concur

Target date for completion: April 30, 2016

Facility response: Chief, Acute Medicine and the Associate Nurse Executive, Inpatient will ensure all inpatient staff (licensed independent practitioners, nursing staff, and social work) are re-educated on the requirements for Advance Directive screening of patients admitted to the facility and the documentation of discussions (creating, changing, and/or revoking advance directives) using appropriate note titles. Monitoring will occur until the target of 90% compliance is sustained for three consecutive months. Results will be reported to Quality Management and the Organizational Excellence Leadership Board.

Recommendation 12. We recommended that Radiology Service revise its policies to require a 30-minute on-call reporting time for computed tomography scans and a 30-minute on-call response time for radiology interpretation.

Concur

Target date for completion: June 30, 2016

Facility response: Radiology Service will revise its policies to require a 30-minute on-call response time to initiate computed tomography scans when fully staffed with 24/7 coverage with a goal of achieving this coverage by 6/30/16. Radiology Service will revise its policies to require a 30-minute on-call time to initiate interpretation of radiologic studies. The policy will be forwarded to the Executive Leadership (PENTAD) for review and final approval by 1/31/16. Monitoring will occur until the target of 90% compliance for the 30-minute on-call reporting time and the 30-minute on-call radiology interpretation time has been sustained for three consecutive months. Results will be reported to Quality Management and the Organizational Excellence Leadership Board.

Recommendation 13. We recommended that the facility ensure clinicians complete all required emergency airway management competency reassessment elements prior to providing emergency airway management coverage and that facility managers monitor compliance.

Concur

Target date for completion: January 31, 2016

Facility response: The Chief of Anesthesiology will continue to implement the current process for emergency airway management skills verification and competency assessment as outlined in the facility policy. Upon completion of training, competency

checklists and skills verification documents will be provided to the Service Chief of Acute Medicine/Emergency Department. The Chief of Acute Medicine will ensure that all Emergency Department providers and all respiratory therapists complete the training by 12/31/2015. Staff will only be scheduled for out of operating room airway management (OOORAM) coverage when all training requirements have been met and documented with final approval by the Chief of Anesthesiology.

The Chief of Acute Medicine and/or designee will monitor and document completion of training by required staff (ED providers and respiratory therapists) monthly using the OOORAM tracking spreadsheet. Status of training will be reported to CPR Committee, the Medical Executive Board, and the Organizational Excellence Leadership Board.

Recommendation 14. We recommended that the facility have appropriate emergency airway management coverage during all hours the facility provides patient care and that facility managers monitor compliance.

Concur

Target date for completion: January 31, 2016

Facility response: Anesthesia will provide emergency airway management coverage during weekdays on dayshift. After hours, emergency room providers or respiratory therapists with documented airway management competencies will provide out of operating room airway management coverage. The Chief of Acute Medicine or designee has developed a schedule to provide the appropriate number of competent staff to support out of operating room airway management after hours. The Chief of Staff or designee will monitor to ensure appropriate staffing has been sustained for three consecutive months. Results will be reported to the Medical Executive Board and Organizational Excellence Leadership Board.

Recommendation 15. We recommended that facility managers ensure that identified deficiencies from the annual pharmacy physical security survey are corrected and monitor compliance.

Concur

Target date for completion: January 31, 2016

Facility response: The FY15 annual pharmacy physical security survey conducted by VA Police Service resulted in notification to Facility Management Service of the continued findings in the main pharmacy, the Pahrump Clinic, and the Pharmacy Cache storage area. VA Police Service will continue to monitor for completion of the work orders created to address the findings every 30 days as required in VA Handbook 0730/4, Appendix B. Results will be reported to the Environment of Care Committee and the Organizational Excellence Leadership Board.

Office of Inspector General
Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the OIG at (202) 461-4720.
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This report is available at www.va.gov/oig.

Endnotes

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

[b] References used for this topic included:
- VHA Directive 2008-052, *Smoke-Free Policy for VA Health Care Facilities*, August 26, 2008.
- VHA Directive 2010-032, *Safe Patient Handling Program and Facility Design*, June 28, 2010.
- VHA Directive 2011-007, *Required Hand Hygiene Practices*, February 16, 2011.
- VA National Center for Patient Safety, "Issues continue to occur due to improper ceiling mounted patient lift installation, maintenance and inspection," Addendum to Patient Safety Alert 14-07, September 3, 2014.
- Various requirements of The Joint Commission, the Occupational Safety and Health Administration, the International Association of Healthcare Central Service Materiel Management, the Health Insurance Portability and Accountability Act, Underwriters Laboratories, VA Master Specifications.

[c] References used for this topic included:
- VHA Directive 2008-027, *The Availability of Potassium Chloride for Injection Concentrate USP*, May 13, 2008.
- VHA Directive 2010-020, *Anticoagulation Therapy Management*, May 14, 2010.
- VHA Handbook 1108.01, *Controlled Substances (Pharmacy Stock)*, November 16, 2010.
- VHA Handbook 1108.05, *Outpatient Pharmacy Services*, May 30, 2006.
- VHA Handbook 1108.06, *Inpatient Pharmacy Services*, June 27, 2006.
- VHA Handbook 1108.07, *Pharmacy General Requirements*, April 17, 2008.
- Various requirements of The Joint Commission.

[d] The reference used for this topic was:
- Under Secretary for Health, "Consult Business Rule Implementation," memorandum, May 23, 2013.

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

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

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

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

[i] The reference used for this topic was:
- VA Handbook 0730, *Security and Law Enforcement*, August 11, 2000.