Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 14-02083-24

Combined Assessment Program Review of the Minneapolis VA Health Care System Minneapolis, Minnesota

November 18, 2014

Washington, DC 20420

To Report Suspected Wrongdoing in VA Programs and Operations
Telephone: 1-800-488-8244
E-Mail: vaoighotline@va.gov
(Hotline Information: www.va.gov/oig/hotline)

Glossary

CAP	Combined Assessment Program
CLC	community living center
EHR	electronic health record
EOC	environment of care
facility	Minneapolis VA Health Care System
FY	fiscal year
MEC	Medical Executive Committee
MH	mental health
MRI	magnetic resonance imaging
NA	not applicable
NM	not met
OIG	Office of Inspector General
PACU	post-anesthesia care unit
PRC	Peer Review Committee
QM	quality management
SDS	same day surgery
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Table of Contents

Executive Summary

Review Purpose: The purpose of the review was to evaluate selected health care facility operations, focusing on patient care quality and the environment of care, and to provide crime awareness briefings. We conducted the review the week of September 22, 2014.

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

- Quality Management
- Environment of Care
- Coordination of Care
- Community Living Center Resident Independence and Dignity

The facility's reported accomplishments were the Opioid Safety Initiative/Chronic Pain Rehabilitation Program and the Women's Imaging Suite.

Recommendations: We made recommendations in the following three activities:

Medication Management: Document patient learning assessments within 24 hours of admission. Complete and document patient discharge progress notes or discharge instructions.

Acute Ischemic Stroke Care: Complete and document National Institutes of Health stroke scales for each stroke patient. Provide printed stroke education to patients upon discharge.

Magnetic Resonance Imaging Safety: Ensure Level 2 personnel conducting secondary patient safety screenings sign the forms prior to the scan.

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 19–23, for the full text of the Directors' comments.) We will follow up on the planned actions until they are completed.

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

Objectives and Scope

Objectives

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

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

Scope

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

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

- QM
- EOC
- Medication Management
- Coordination of Care
- Acute Ischemic Stroke Care
- CLC Resident Independence and Dignity
- MRI Safety

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 2012, FY 2013, and FY 2014 through September 22, 2014, 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 Minneapolis VA Health Care System, Minneapolis, Minnesota,* Report No. 12-02599-03, October 10, 2012).

During this review, we presented crime awareness briefings for 68 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 220 responded. We shared summarized results with facility managers.

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

Reported Accomplishments

Opioid Safety Initiative and Chronic Pain Rehabilitation Program

The facility has become a VA leader for patient safety in opioid prescribing. From April 1, 2011, to August 1, 2014, the number of veterans on long-term, high dose opioid therapy (greater than 200 morphine equivalents per day) was reduced by 78 percent. This was accomplished with a quality improvement team process using internal system changes and through improved communication with and education for veterans, increased provider education and support, and use of behavioral health services as needed.

In FY 2014, the facility started a 3–4 week intensive outpatient treatment program to provide interdisciplinary rehabilitative therapy to veterans and active duty service members with chronic, debilitating, non-cancer pain. The program assists veterans in achieving increased self-management of chronic pain, withdrawing from opioids, improving confidence in managing pain independently, increasing function in multiple domains of life, and addressing physical and emotional co-morbidities that may exacerbate chronic pain syndrome or impede maintenance of rehabilitation gains. This program received full 3-year accreditation by the Commission on Accreditation of Rehabilitation Facilities.

Women's Imaging Suite

As part of the facility's program development and commitment to women veterans, the Diagnostic Imaging Service recently completed construction of the Women's Imaging Suite. The suite is mammography certified and provides ultrasound. Previously, approximately 1,000 women per year were referred to non-VA community providers for mammography. By providing onsite breast imaging, the facility is able to provide more thorough, complete, and timely care for women veterans.

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, EHRs, and other relevant documents. The table below shows the areas reviewed for this topic. Any items that did not apply to this facility are marked NA. The facility generally met requirements. We made no recommendations.

NM	Areas Reviewed	Findings
	There was a senior-level committee/group responsible for QM/performance improvement that met regularly. • There was evidence that outlier data was acted upon. • There was evidence that QM, patient safety, and systems redesign were integrated.	
	The protected peer review process met selected requirements: • The PRC was chaired by the Chief of Staff and included membership by applicable service chiefs. • Actions from individual peer reviews were completed and reported to the PRC. • The PRC submitted quarterly summary reports to the MEC. • Unusual findings or patterns were discussed at the MEC.	
	Focused Professional Practice Evaluations for newly hired licensed independent practitioners were initiated and completed, and results were reported to the MEC.	
	Specific telemedicine services met selected requirements: • Services were properly approved. • Services were provided and/or received by appropriately privileged staff. • Professional practice evaluation information was available for review.	

NM	Areas Reviewed (continued)	Findings
	Observation bed use met selected requirements: • Local policy included necessary elements. • Data regarding appropriateness of observation bed usage was gathered. • If conversions to acute admissions were consistently 30 percent or more, observation criteria and utilization were re-assessed timely.	
	Staff performed continuing stay reviews on at least 75 percent of patients in acute beds.	
	The process to review resuscitation events met selected requirements: • An interdisciplinary committee was responsible for reviewing 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. • Data were collected that measured performance in responding to events.	
	The surgical review process met selected requirements: • An interdisciplinary committee with appropriate leadership and clinical membership met monthly to review surgical processes and outcomes. • Surgical deaths with identified problems or opportunities for improvement were reviewed. • Additional data elements were routinely reviewed.	
	Critical incidents reporting processes were appropriate.	
	The process to review the quality of entries in the EHR met selected requirements: • A committee was responsible to review EHR quality. • Data were collected and analyzed at least quarterly. • Reviews included data from most services and program areas.	
	The policy for scanning non-VA care documents met selected requirements.	

NM	Areas Reviewed (continued)	Findings
	The process to review blood/transfusions usage met selected requirements: • A committee with appropriate clinical membership met at least quarterly to review blood/transfusions usage. • Additional data elements were routinely reviewed.	
	Overall, if significant issues were identified, actions were taken and evaluated for effectiveness.	
	Overall, senior managers were involved in performance improvement over the past 12 months.	
	Overall, the facility had a comprehensive, effective QM/performance improvement 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 and whether the facility met selected requirements in SDS, the PACU, and the eye clinic.[b]

We inspected the inpatient MH, medicine and telemetry, medical intensive care, and surgical units; the inpatient Spinal Cord Injury/Disorder Center; Physical Medicine and Rehabilitation Service; the emergency department; three CLCs; SDS; the PACU; and the eye clinic. Additionally, we reviewed relevant documents, conversed with key employees and managers, and reviewed 25 employee training records (10 SDS, 10 PACU, and 5 eye clinic). The table below shows the areas reviewed for this topic. Any items that did not apply to this facility are marked NA. The facility generally met requirements. We made no recommendations.

NM	Areas Reviewed for General EOC	Findings
	EOC Committee minutes reflected sufficient detail regarding identified deficiencies, corrective actions taken, and tracking of corrective actions 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.	
	Fire safety requirements were met.	
	Environmental safety requirements were met.	
	Infection prevention requirements were met.	
	Medication safety and security requirements were met.	
	Auditory privacy requirements were met.	
	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.	
	Areas Reviewed for SDS and the PACU	
	Designated SDS and PACU employees received bloodborne pathogens training during the past 12 months.	
	Designated SDS employees received medical laser safety training with the frequency required by local policy.	
	Fire safety requirements in SDS and on the PACU were met.	
	Environmental safety requirements in SDS and on the PACU were met.	

NM	Areas Reviewed for SDS and the PACU (continued)	Findings
	SDS medical laser safety requirements were met.	
	Infection prevention requirements in SDS and on the PACU were met.	
	Medication safety and security requirements in SDS and on the PACU were met.	
	Auditory privacy requirements in SDS and on the PACU were met.	
	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.	
	Areas Reviewed for Eye Clinic	
	Designated eye clinic employees received laser safety training with the frequency required by local policy.	
	Environmental safety requirements in the eye clinic were met.	
	Infection prevention requirements in the eye clinic were met.	
	Medication safety and security requirements in the eye clinic were met.	
	Laser safety requirements in the eye clinic were met.	
	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.	

Medication Management

The purpose of this review was to determine whether the appropriate clinical oversight and education were provided to patients discharged with orders for fluoroquinolone oral antibiotics.[c]

We reviewed relevant documents and conversed with key managers and employees. Additionally, we reviewed the EHRs of 32 randomly selected inpatients discharged on 1 of 3 selected oral antibiotics. 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
X	Clinicians conducted inpatient learning assessments within 24 hours of admission or earlier if required by local policy.	• For 6 of the 29 applicable patients, learning assessments were conducted more than 24 hours after admission.
	If learning barriers were identified as part of the learning assessment, medication counseling was adjusted to accommodate the barrier(s).	
	Patient renal function was considered in fluoroquinolone dosage and frequency.	
X	Providers completed discharge progress notes or discharge instructions, written instructions were provided to patients/caregivers, and EHR documentation reflected that the instructions were understood.	• For 15 of the 32 patients (47 percent), EHRs did not contain providers' discharge progress notes or discharge instructions.
	Patients/caregivers were provided a written medication list at discharge, and the information was consistent with the dosage and frequency ordered.	
	Patients/caregivers were offered medication counseling, and this was documented in patient EHRs.	
	The facility established a process for patients/caregivers regarding whom to notify in the event of an adverse medication event.	
	The facility complied with any additional elements required by VHA or local policy.	

Recommendations

1. We recommended that processes be strengthened to ensure that patient learning assessments are documented within 24 hours of admission and that compliance be monitored.

2. We recommended that processes be strengthened to ensure that providers complete and document patient discharge progress notes or discharge instructions and that compliance be monitored.

Coordination of Care

The purpose of this review was to evaluate discharge planning for patients with selected aftercare needs.[d]

We reviewed relevant documents, and we conversed with key employees. Additionally, we reviewed the EHRs of 28 randomly selected patients with specific diagnoses who were discharged from July 1, 2012, through June 30, 2013. 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
	Patients' post-discharge needs were identified, and discharge planning addressed the identified needs.	
	Clinicians provided discharge instructions to patients and/or caregivers and validated their understanding.	
	Patients received the ordered aftercare services and/or items within the ordered/expected timeframe.	
	Patients' and/or caregivers' knowledge and learning abilities were assessed during the inpatient stay.	
	The facility complied with any additional elements required by VHA or local policy.	

Acute Ischemic Stroke Care

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

We reviewed relevant documents, the EHRs of 38 randomly selected patients who experienced stroke symptoms, and 15 employee training records (5 emergency department, 5 medical intensive care unit, and 5 medicine unit), and we conversed with key employees. We also conducted onsite inspections of the emergency department, the medical intensive care unit, and one medicine unit. The table below shows the areas reviewed for this topic. The areas marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

NM	Areas Reviewed	Findings
	The facility's stroke policy/plan/guideline addressed all required items.	
X	Clinicians completed the National Institutes of Health stroke scale for each patient within the expected timeframe.	• Fourteen EHRs (37 percent) did not contain documented evidence of completed stroke scales.
	Clinicians provided medication (tissue plasminogen activator) timely to halt the stroke and included all required steps, and tissue plasminogen activator was in stock or available within 15 minutes.	
	Stroke guidelines were posted in all areas where patients may present with stroke symptoms.	
	Clinicians screened patients for difficulty swallowing prior to oral intake of food or medicine.	
X	Clinicians provided printed stroke education to patients upon discharge.	• Twenty-one EHRs (55 percent) did not contain documentation that stroke education was provided to the patient/caregiver.
	The facility provided training to staff involved in assessing and treating stroke patients.	
	The facility collected and reported required data related to stroke care.	
	The facility complied with any additional elements required by VHA or local policy.	

Recommendations

3. We recommended that processes be strengthened to ensure that clinicians complete and document National Institutes of Health stroke scales for each stroke patient and that compliance be monitored.

4. We recommended that processes be strengthened to ensure that clinicians provide printed stroke education to patients upon discharge and that compliance be monitored.

CLC Resident Independence and Dignity

The purpose of this review was to determine whether the facility provided CLC restorative nursing services and complied with selected nutritional management and dining service requirements to assist CLC residents in maintaining their optimal level of functioning, independence, and dignity.[f]

We observed three residents during two meal periods, reviewed relevant documents, and conversed with key employees. The table below shows the areas reviewed for this topic. Any items that did not apply to this facility are marked NA. The facility generally met requirements. We made no recommendations.

NM	Areas Reviewed	Findings
	The facility offered restorative nursing services or provided restorative interventions through Physical Medicine and Rehabilitation therapies.	
NA	Facility staff completed and documented restorative nursing services, including active and passive range of motion, bed mobility, transfer, and walking activities, according to clinician orders and residents' care plans.	
NA	Resident progress towards restorative nursing goals was documented, and interventions were modified as needed to promote the resident's accomplishment of goals.	
NA	When restorative nursing services were care planned but were not provided or were discontinued, reasons were documented in the EHR.	
NA	If residents were discharged from physical therapy, occupational therapy, or kinesiotherapy, there was hand-off communication between Physical Medicine and Rehabilitation Service and the CLC to ensure that restorative nursing services occurred.	
NA	Training and competency assessment were completed for staff who performed restorative nursing services.	
	The facility complied with any additional elements required by VHA or local policy.	
	Areas Reviewed for Assistive Eating Devices and Dining Service	
	Care planned/ordered assistive eating devices were provided to residents at meal times.	
	Required activities were performed during resident meal periods.	

NM	Areas Reviewed for Assistive Eating Devices and Dining Service (continued)	Findings
	The facility complied with any additional elements required by VHA or local policy.	

MRI Safety

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

We reviewed relevant documents and the training records of 146 employees (30 randomly selected Level 1 ancillary staff and 116 designated Level 2 MRI personnel), and we conversed with key managers and employees. We also reviewed the EHRs of 34 randomly selected patients who had an MRI January 1–December 31, 2013. Additionally, we conducted physical inspections of two MRI areas. 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
	The facility completed an MRI risk assessment, there were documented procedures for handling emergencies in MRI, and emergency drills were conducted in the MRI area.	
X	Two patient safety screenings were conducted prior to MRI, and the secondary patient safety screening form was signed by the patient, family member, or caregiver and reviewed and signed by a Level 2 MRI personnel.	• Twelve secondary patient safety screening forms (35 percent) were not signed by Level 2 MRI personnel prior to MRI.
	Any MRI contraindications were noted on the secondary patient safety screening form, and a Level 2 MRI personnel and/or radiologist addressed the contraindications and documented resolution prior to MRI.	
	Level 1 ancillary staff and Level 2 MRI personnel were designated and received level-specific annual MRI safety training.	
	Signage and barriers were in place to prevent unauthorized or accidental access to Zones III and IV.	
	MRI technologists maintained visual contact with patients in the magnet room and two-way communication with patients inside the magnet, and the two-way communication device was regularly tested.	
	Patients were offered MRI-safe hearing protection for use during the scan.	
	The facility had only MRI-safe or compatible equipment in Zones III and IV, or the equipment was appropriately protected from the magnet.	
	The facility complied with any additional elements required by VHA or local policy.	

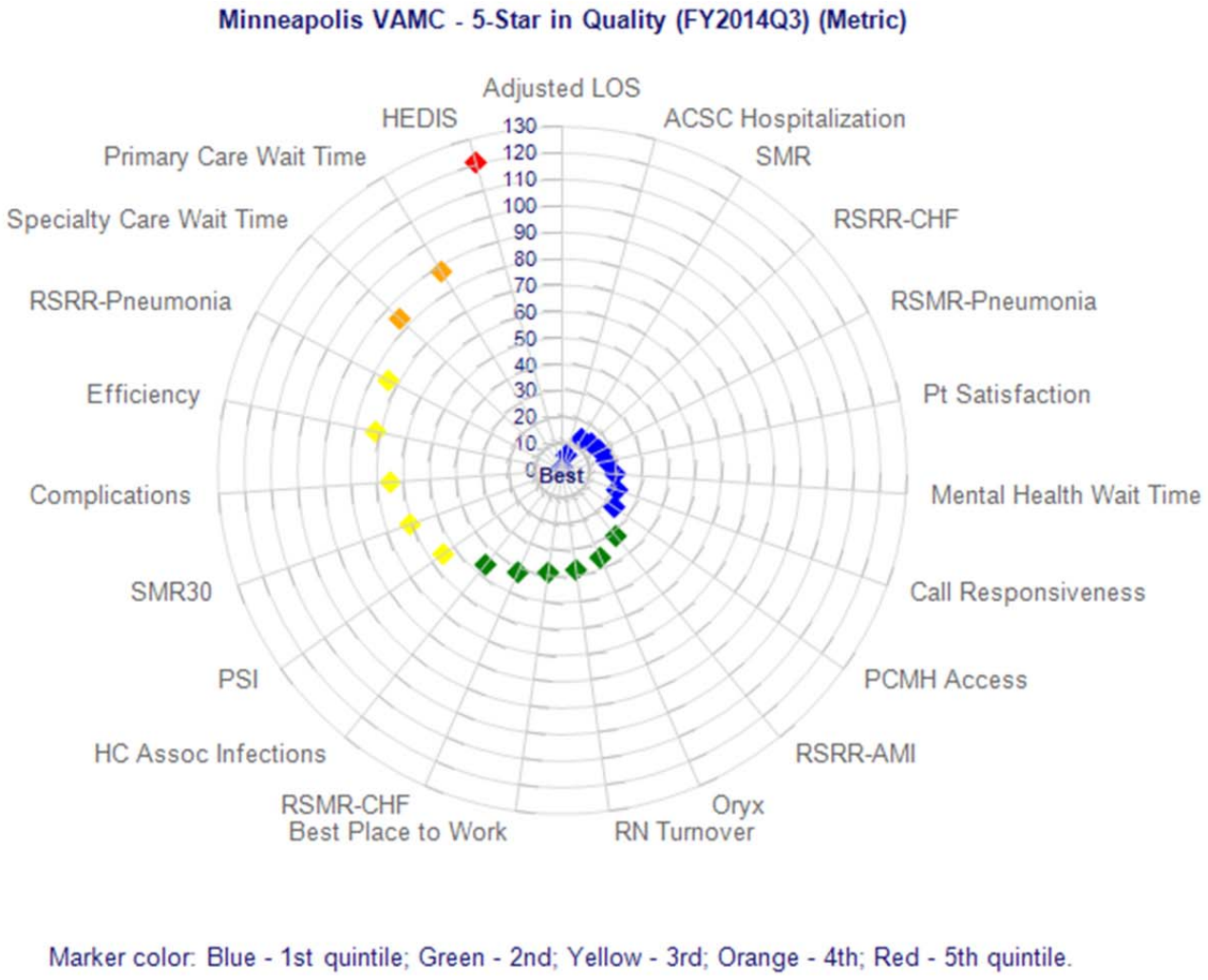
Recommendation

5. We recommended that processes be strengthened to ensure that Level 2 magnetic resonance imaging personnel conducting secondary patient safety screenings sign the forms prior to magnetic resonance imaging and that compliance be monitored.

Facility Profile (Minneapolis/618) FY 2014 through August 2014[1]	
Type of Organization	Tertiary
Complexity Level	1a-High complexity
Affiliated/Non-Affiliated	Affiliated
Total Medical Care Budget in Millions	$758.2
Number of:	
• **Unique Patients**	95,978
• **Outpatient Visits**	758,508
• **Unique Employees**[2]	3,282
Type and Number of Operating Beds (July 2014):	
• **Hospital**	225
• **CLC**	80
• **MH**	NA
Average Daily Census (July 2014):	
• **Hospital**	135
• **CLC**	65
• **MH**	NA
Number of Community Based Outpatient Clinics	9
Location(s)/Station Number(s)	Mankato/618GA Hibbing/618GB Maplewood/618GD Eau Claire/618GE Rochester/618GG Hayward/Rice Lake/618GH Northwest Metro/618GI Shakopee/618GJ Albert Lea/618GK
VISN Number	23

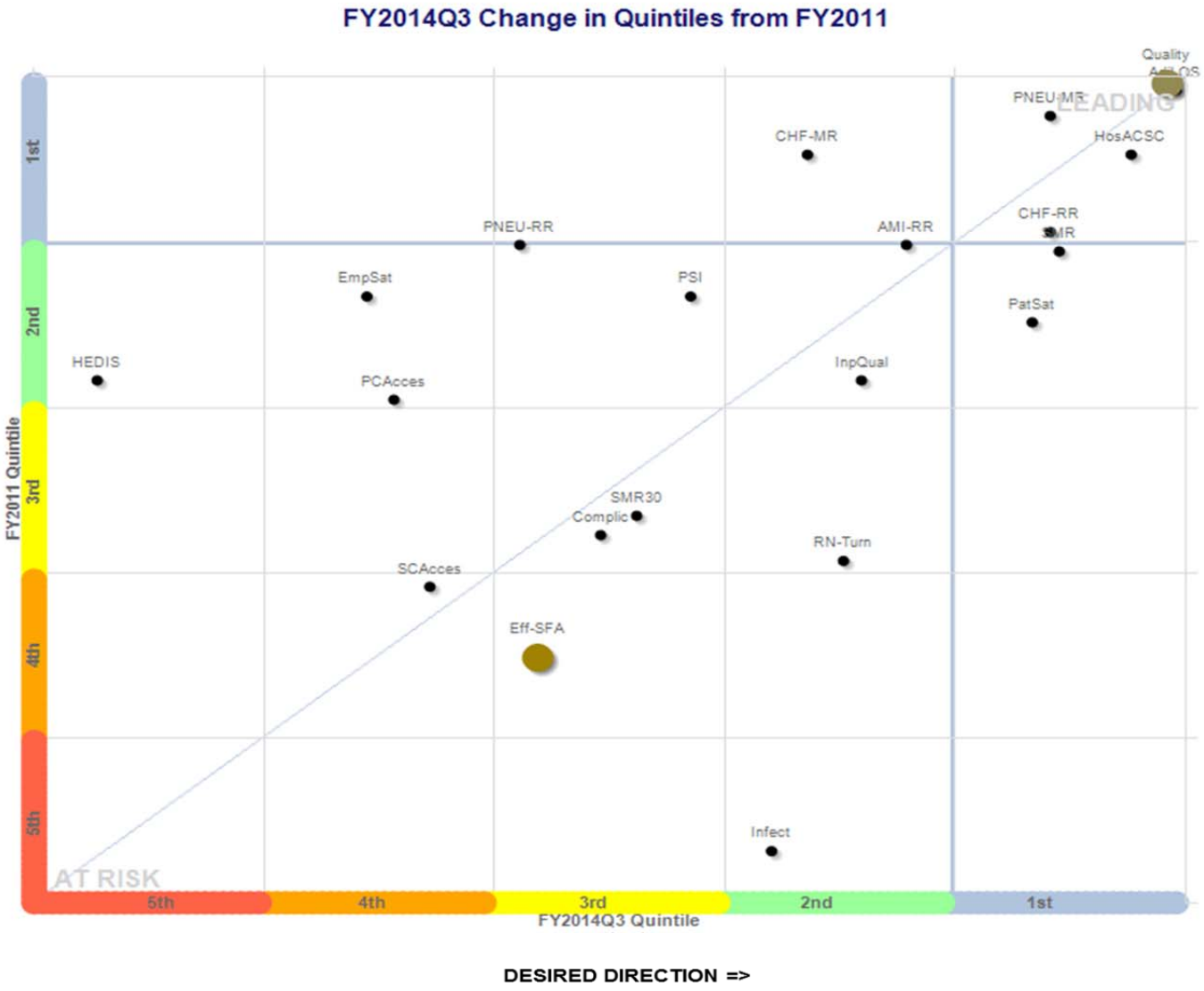
[1] All data is for FY 2014 through August 2014 except where noted.
[2] Unique employees involved in direct medical care (cost center 8200) from most recent pay period.

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



[3] 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 Status	MH status (outpatient only, the Veterans RAND 12 Item Health Survey)	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
Oryx	Inpatient performance measure (ORYX)	A higher value is better than a lower value
Physical Health Status	Physical health status (outpatient only, the Veterans RAND 12 item Health Survey)	A higher value is better than a lower value
Primary Care Wait Time	Primary care wait time for new and established patients (top 50 clinics; FY13 and later)	A higher value is better than a lower value
PSI	Patient safety indicator (observed to expected ratio)	A lower value is better than a higher value
Pt Satisfaction	Overall rating of hospital stay (inpatient only)	A higher value is better than a lower value
RN Turnover	Registered nurse turnover rate	A lower value is better than a higher value
RSMR-AMI	30-day risk standardized mortality rate for acute myocardial infarction	A lower value is better than a higher value
RSMR-CHF	30-day risk standardized mortality rate for congestive heart failure	A lower value is better than a higher value
RSMR-Pneumonia	30-day risk standardized mortality rate for pneumonia	A lower value is better than a higher value
RSRR-AMI	30-day risk standardized readmission rate for acute myocardial infarction	A lower value is better than a higher value
RSRR-CHF	30-day risk standardized readmission rate for congestive heart failure	A lower value is better than a higher value
RSRR-Pneumonia	30-day risk standardized readmission rate for pneumonia	A lower value is better than a higher value
SMR	Acute care in-hospital standardized mortality ratio	A lower value is better than a higher value
SMR30	Acute care 30-day standardized mortality ratio	A lower value is better than a higher value
Specialty Care Wait Time	Specialty care wait time for new and established patients (top 50 clinics; FY13 and later)	A higher value is better than a lower value

Appendix C

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: October 21, 2014

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

Subject: **CAP Review of the Minneapolis VA Health Care System, Minneapolis, MN**

To: Director, Denver Office of Healthcare Inspections (54DV)

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

I have reviewed the report of the Combined Assessment Program Review at the Minneapolis VA Health Care System conducted September 22–26, 2014, in addition to the MVAHCS response and action plans. I concur with the facility response and action plans. Thank you for the opportunity to review this report.

(original signed by:)
JANET P. MURPHY, MBA
Network Director

Facility Director Comments

Department of Veterans Affairs **Memorandum**

Date: October 20, 2014

From: Director, Minneapolis VA Health Care System (618/00)

Subject: **CAP Review of the Minneapolis VA Health Care System, Minneapolis, MN**

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

1. Thank you for the opportunity to review the draft report of recommendations from the **CAP Review of the Minneapolis VA Health Care System,** conducted September 22–26, 2014. I have reviewed the report and I concur with the recommendations and the action plans.

2. If you have any questions please feel free to contact me at (612) 725-2101.

(original signed by:)
Patrick J. Kelly, FACHE
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 patient learning assessments are documented within 24 hours of admission and that compliance be monitored.

Concur

Target date for completion: March 1, 2015

Facility response: The Nurse Executive and the Nurse Practice Council approved a plan to revise the Nursing Admission Database to ensure that learning assessments are completed within 24 hours of admission. Education will be provided to nursing staff about what's required. Audits will be conducted and reported to Medical Records Committee and to the Executive Committee of the Nursing Staff to ensure that learning assessments are completed within 24 hours of admission. Audits will be conducted monthly until 90% compliance is achieved for three consecutive months, and then will be quarterly for the following year.

Recommendation 2. We recommended that processes be strengthened to ensure that providers complete and document patient discharge progress notes or discharge instructions and that compliance be monitored.

Concur

Target date for completion: March 1, 2015

Facility response: The medical staff providers consistently complete a Discharge Summary but did not consistently complete a patient discharge progress note. The medical staff will develop a CPRS progress note template to document discharge instructions. Medical staff will be educated about the requirement to complete this progress note at discharge. Audits will be conducted monthly until 90% compliance is achieved for three consecutive months, and then quarterly for the coming year to ensure that providers complete a patient discharge progress note as required. Audit results will be reported to the Executive Committee of the Medical Staff.

Recommendation 3. We recommended that processes be strengthened to ensure that clinicians complete and document National Institutes of Health stroke scales for each stroke patient and that compliance be monitored.

Concur

Target date for completion: February 1, 2015

Facility response: Neurology Providers are assigned to complete NIH stroke scales for stroke patients. The process was strengthened by making revisions to CPRS templates for Neurology and ED physicians. An education program for Neurology Residents regarding completion of NIH stroke scales was formalized, and completion of face to face education is now documented in the local TMS. The NIH stroke scales will be documented by ED Providers upon initial evaluation as well.

Audits of patient records in Quarter 4 2014, showed that NIH stroke scales were documented for each stroke patient 97% of the time. Audits will continue with feedback to Neurology and ED staff regarding performance. Monthly audits will be conducted until 90% compliance is achieved for three consecutive months, and quarterly thereafter. Compliance will be reported to the Executive Committee of the Medical Staff and to the Stroke Care Sub-committee.

Recommendation 4. We recommended that processes be strengthened to ensure that clinicians provide printed stroke education to patients upon discharge and that compliance be monitored.

Concur

Target date for completion: April 1, 2015

Facility response: Patients receive written instructions at the time of discharge. The documentation includes a CPRS progress note that indicates patient instructions and key information. The Nurse Practice Council and the Nurse Executive have approved a plan to revise the CPRS progress note to ensure that staff document that printed stroke education is given to patients upon discharge. Education will be provided to nursing staff about what's required. Monthly audits will be conducted until 90% compliance is achieved for three consecutive months, and quarterly audits will be conducted thereafter. Compliance will be reported to the Executive Committee of the Nursing Staff.

Recommendation 5. We recommended that processes be strengthened to ensure that Level 2 magnetic resonance imaging personnel conducting secondary patient safety screenings sign the forms prior to magnetic resonance imaging and that compliance be monitored.

Concur

Target date for completion: January 1, 2015

Facility response: All patients had a secondary safety assessment, however 10 of 12 records reviewed did not have a signature. Since the implementation of a new form for documenting the secondary safety assessment, the signature of the staff conducting the assessment has been present. In a recent review of 100 records in FY 2014, the staff signature was present 93% of the time. Monthly audits will be conducted until 90% compliance is maintained for three consecutive months, and then quarterly audits will continue for the coming year. Results will be reported to the Imaging PSL Management Meeting.

OIG Contact and Staff Acknowledgments

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

Endnotes

[a] References used for this topic included:
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