Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 14-04228-144

Combined Assessment Program Review of the VA Central Western Massachusetts Healthcare System Leeds, Massachusetts

March 4, 2015

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
EAM	emergency airway management
EHR	electronic health record
EOC	environment of care
facility	VA Central Western Massachusetts Healthcare System
FY	fiscal year
MH	mental health
NA	not applicable
NM	not met
OIG	Office of Inspector General
QM	quality management
VHA	Veterans Health Administration

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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 December 8, 2014.

Review Results: The review covered five activities. We made no recommendations in the following activity:

- Emergency Airway Management

Recommendations: We made recommendations in the following four activities:

Quality Management: Review privilege forms annually, and document the review. Ensure licensed independent practitioners' folders do not contain licensure verification information. Establish a committee to provide oversight of the safe patient handling program. Revise the scanning quality control policy/process to include all required elements.

Environment of Care: Ensure Environment of Care Committee minutes reflect sufficient detail regarding corrective actions for identified deficiencies and track corrective actions to closure. Repair damaged floors and walls and repair or replace damaged furnishings, plumbing fixtures, and windows. Ensure all required Environment of Care Committee members consistently attend committee meetings. Conduct and document annual complete system checks of the community living center's elopement prevention system.

Medication Management: Revise the policy for safe use of automated dispensing machines to include oversight of overrides and employee training and minimum competency requirements for users.

Coordination of Care: Require Mental Health Service's Automated Data Processing Application Coordinators to provide computerized consult package training to employees. Ensure that consult requestors consistently select the proper consult title and that consultants do not change the consult request status for inappropriate reasons.

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 21–27, for

the full text of the Directors' comments.) We consider recommendations 3 and 4 closed. We will follow up on the planned actions for the open recommendations until they are completed.

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

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 five activities:

- QM
- EOC
- Medication Management
- Coordination of Care
- EAM

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 October 29, 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 VA Central Western Massachusetts Healthcare System, Leeds, Massachusetts,* Report No. 12-03072-48, December 4, 2012).

During this review, we presented a crime awareness briefing for 32 employees. This briefing 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 197 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.

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, 11 credentialing and privileging folders, and other relevant documents. The table below shows the areas reviewed for this topic. The areas marked as NM did not meet applicable requirements and needed improvement. 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.	• Facility managers did not review privilege forms annually. • All 11 of the licensed independent practitioners' folders reviewed contained licensure verification information.	**1.** We recommended that facility managers review privilege forms annually and document the review. **2.** We recommended that the facility ensure that licensed independent practitioners' folders do not contain licensure verification 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
NA	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.		
NA	Clinicians appropriately reported critical incidents.		
X	The safe patient handling program met selected requirements: • A committee provided program oversight. • The committee gathered, tracked, and shared patient handling injury data.	• The facility did not have a committee that provided oversight of the safe patient handling program.	**3.** We recommended that the facility establish a committee to provide oversight of the safe patient handling program.
	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.		

NM	Areas Reviewed (continued)	Findings	Recommendations
X	The policy/process 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. • 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.	• The scanning policy/process did not include an alternative means of capturing data when the quality of the source document does not meet image quality controls, a complete review of scanned documents to ensure retrievability, and quality assurance reviews on a sample of the scanned documents.	**4.** We recommended that the quality control policy/process for scanning include an alternative means of capturing data when the quality of the source document does not meet image quality controls, a complete review of scanned documents to ensure retrievability, 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 the CLC.[b]

We inspected the CLC, post-traumatic stress disorder, acute MH, and sub-acute MH inpatient units. We also inspected the primary care, urgent care, physical therapy, and occupational therapy clinics. Additionally, we reviewed relevant documents, including 10 CLC employee training 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.	Seven months of EOC Committee meeting minutes reviewed: • Minutes did not reflect sufficient detail regarding corrective actions for identified deficiencies. • Minutes did not track corrective actions to closure.	**5.** We recommended that Environment of Care Committee minutes reflect sufficient detail regarding corrective actions for identified deficiencies and track corrective actions to closure.
	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.		
	Selected employees received training on updated requirements regarding chemical labeling and safety data sheets.		
	The facility met fire safety requirements.		

NM	Areas Reviewed for General EOC (continued)	Findings	Recommendations
X	The facility met environmental safety requirements.	• Six of seven patient care areas had damaged floors and walls. • Three of seven patient care areas had damaged furnishings and plumbing fixtures. • Two of seven patient care areas had damaged windows or windows that would not close properly.	**6.** We recommended that the facility repair damaged floors and walls in patient care areas. **7.** We recommended that the facility repair or replace damaged furnishings, plumbing fixtures, and windows in patient care areas.
	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.	Local policy on the EOC program and 7 months of EOC Committee meeting minutes reviewed: • Less than 50 percent of EOC Committee members were present at five of seven meetings.	**8.** We recommended that all required Environment of Care Committee members consistently attend committee meetings and that facility managers monitor compliance.
	Areas Reviewed for Critical Care		
NA	Designated critical care employees received bloodborne pathogens training during the past 12 months.		
NA	Alarm-equipped medical devices used in critical care were inspected/checked according to local policy and/or manufacturers' recommendations.		
NA	The facility met fire safety requirements in critical care.		
NA	The facility met environmental safety requirements in critical care.		
NA	The facility met infection prevention requirements in critical care.		

NM	Areas Reviewed for Critical Care (continued)	Findings	Recommendations
NA	The facility met medication safety and security requirements in critical care.		
NA	The facility met medical equipment requirements in critical care.		
NA	The facility met privacy requirements in critical care.		
NA	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.		
	Areas Reviewed for CLC		
	Designated CLC employees received bloodborne pathogens training during the past 12 months.		
	For CLCs with resident animal programs, the facility conducted infection prevention risk assessments and had policies addressing selected requirements.		
X	For CLCs with elopement prevention systems, the facility documented functionality checks at least every 24 hours and documented complete system checks annually.	• The facility did not have evidence of an annual complete system check of the CLC elopement prevention system.	**9.** We recommended that the facility conduct and document annual complete system checks of the community living center's elopement prevention system and that facility managers monitor compliance.
	The facility met fire safety requirements in the CLC.		
X	The facility met environmental safety requirements in the CLC.	• The unit had damaged floors and walls. • The unit had damaged furnishings and plumbing fixtures.	See recommendation 6. See recommendation 7.
	The facility met infection prevention requirements in the CLC.		
	The facility met medication safety and security requirements in the CLC.		

NM	Areas Reviewed for CLC (continued)	Findings	Recommendations
	The facility met medical equipment requirements in the CLC.		
	The facility met privacy requirements in the CLC.		
	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.		
	Areas Reviewed for Construction Safety		
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 and pharmacy monthly medication storage area inspection documentation for the past 6 months. Additionally, we inspected the urgent care clinic and the CLC, acute MH, and sub-acute MH inpatient units and for these areas reviewed documentation of narcotic wastage from the automated dispensing machines. 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
	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.		
NA	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.		
	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
	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 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 every 30 days, fully implemented corrective actions, and monitored the changes.		
X	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.	• Facility policy for safe use of automated dispensing machines did not include oversight of overrides and employee training and minimum competency requirements for users.	**10.** We recommended that the facility revise the policy for safe use of automated dispensing machines to include oversight of overrides and employee training and minimum competency requirements for users.
	The facility employed practices to prevent wrong-route drug errors.		
	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.		

NM	Areas Reviewed (continued)	Findings	Recommendations
	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 25 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 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
	A committee oversaw the facility's consult management processes.		
X	Major bed services had designated employees to: • Provide training in the use of the computerized consult package • Review and manage consults	• MH Service's Automated Data Processing Applications Coordinators did not provide training in the use of the computerized consult package.	**11.** We recommended that Mental Health Service's Automated Data Processing Applications Coordinators provide training in the use of the computerized consult package and that facility managers monitor compliance.
X	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 did not include "inpatient" in the title. • For five consult requests, consultants documented the following inappropriate change to the consult status—outpatient appointment scheduled using inpatient consult.	**12.** We recommended that requestors consistently select the proper consult title and that facility managers monitor compliance. **13.** We recommended that consultants do not change the consult request status for inappropriate reasons and that facility managers monitor compliance.
	The facility met 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.[e]

We reviewed relevant documents, and we conversed with key managers and 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.

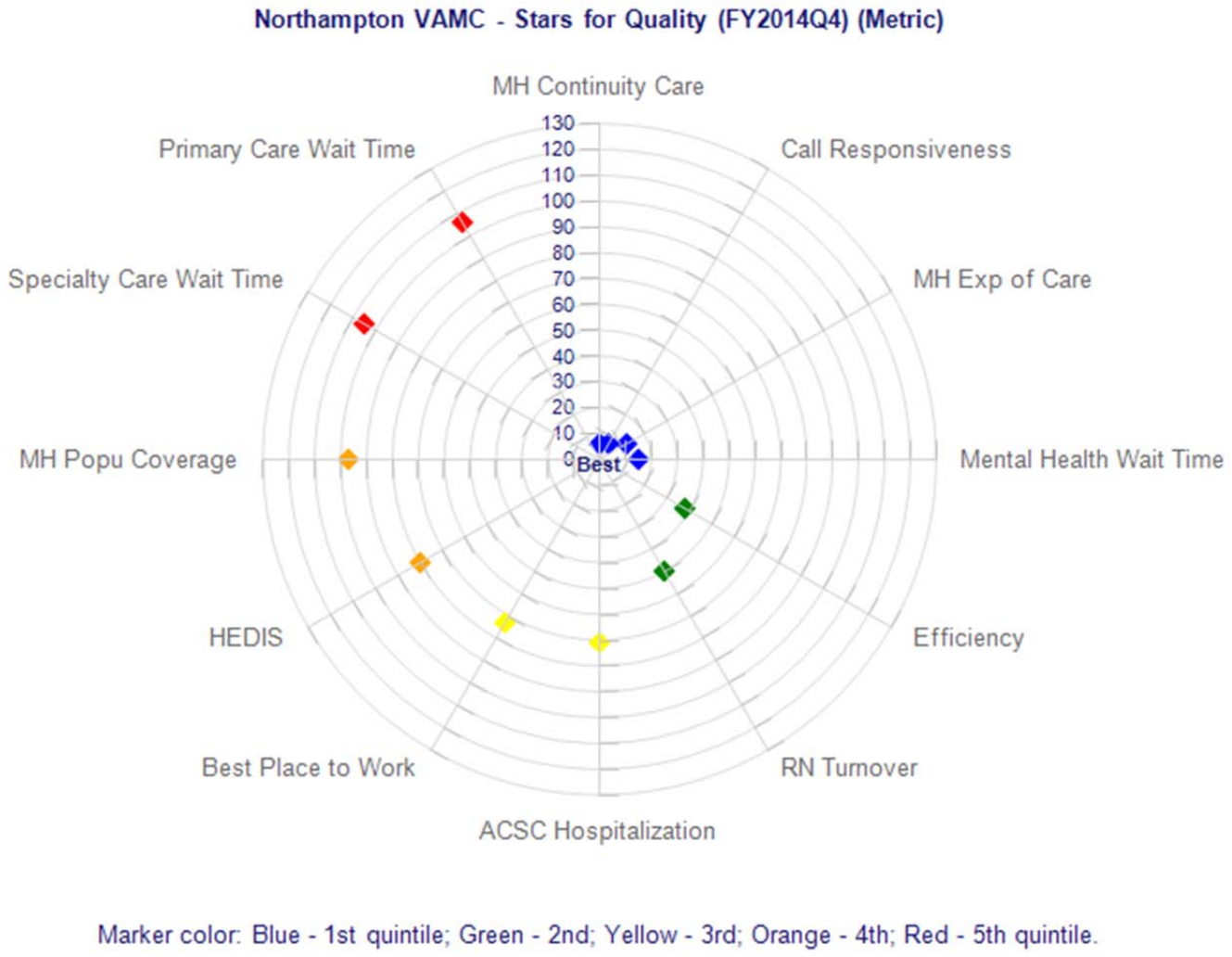
NM	Areas Reviewed	Findings	Recommendations
	The facility had a local EAM policy or had a documented exemption.		
	If the facility had an exemption, it did not have employees privileged to perform procedures using moderate or deep sedation that might lead to airway compromise.		
NA	Facility policy designated a clinical subject matter expert, such as the Chief of Staff or Chief of Anesthesia, to oversee EAM.		
NA	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
NA	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		
NA	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.		
NA	Video equipment to confirm proper placement of breathing tubes was available for immediate clinician use.		
NA	The facility complied with any additional elements required by VHA or local policy.		

Facility Profile (Leeds/631) FY 2015 through December 2014[1]	
Type of Organization	Secondary
Complexity Level	3-Low complexity
Affiliated/Non-Affiliated	Affiliated
Total Medical Care Budget in Millions	$125.6
Number of:	
• **Unique Patients**	17,307
• **Outpatient Visits**	79,208
• **Unique Employees**[2]	785
Type and Number of Operating Beds (as of November):	
• **Hospital**	NA
• **CLC**	32
• **MH**	85
Average Daily Census (as of November):	
• **Hospital**	NA
• **CLC**	27.6
• **MH**	54.3
Number of Community Based Outpatient Clinics	5
Location(s)/Station Number(s)	Springfield/631BY Pittsfield/631GC Greenfield/631GD Worcester/631GE Fitchburg/631GF
Veterans Integrated Service Network Number	1

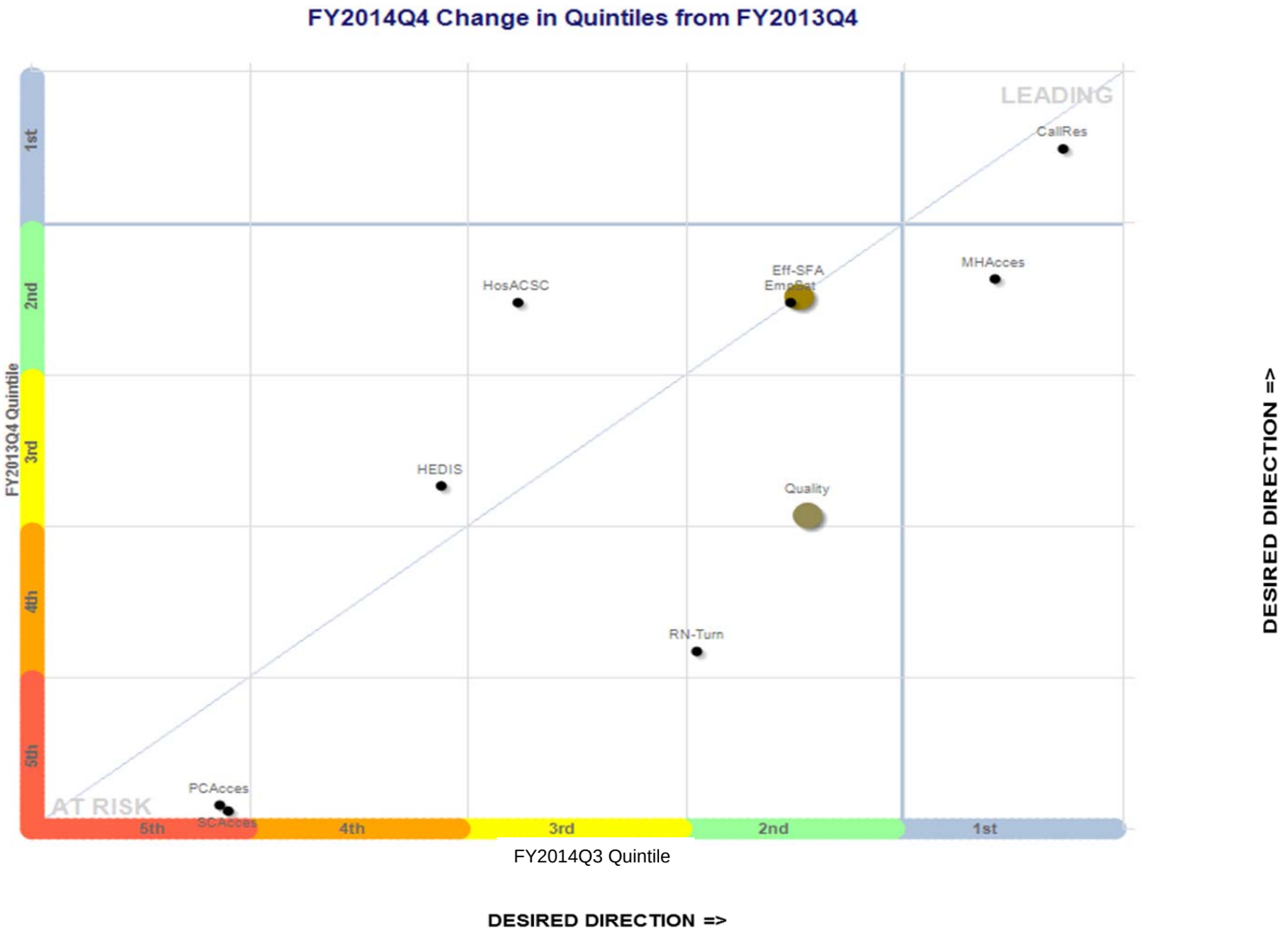
[1] All data is for FY 2015 through December 2014 except where noted.
[2] Unique employees involved in direct medical care (cost center 8200).

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

Veterans Integrated Service Network Director Comments

Department of Veterans Affairs

Memorandum

Date: February 5, 2015

From: Director, VA New England Healthcare System (10N1)

Subject: **CAP Review of the VA Central Western Massachusetts Healthcare System, Leeds, MA**

To: Director, Bedford Office of Healthcare Inspections (54BN)

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

I have reviewed and concur with the action plans regarding the Draft Report, Combined Assessment Program Review of the VA Central Western Massachusetts Healthcare System at Leeds, Massachusetts.

Sincerely,

for Michael F. Mayo-Smith, MD, MPH
Network Director

Facility Director Comments

Department of Veterans Affairs

Memorandum

Date: February 5, 2015

From: Director, VA Central Western Massachusetts Healthcare System (631/00)

Subject: **CAP Review of the VA Central Western Massachusetts Healthcare System, Leeds, MA**

To: Director, VA New England Healthcare System (10N1)

I concur with the recommendations outlined in the attached report. All findings have been reviewed and facility level action plans initiated addressing each recommendation.

Sincerely,

John P. Collins, 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 facility managers review privilege forms annually and document the review.

Concur

Target date for completion: April 30, 2015

Facility response: Privilege forms will be reviewed annually by service line managers in the Credentialing and Privileging Committee and will be recorded in committee minutes. The review process has been placed as a recurring agenda item annually to ensure that reviews are completed yearly as required. Privilege forms were circulated to managers at the October 2014 Credentialing and Privileging Committee meeting and revisions are currently in process. It is expected that revisions will be reviewed by committee members at the February 2015 Credentialing and Privileging Committee and then forwarded to the Executive Committee of the Medical Staff and Director for approval. Local policy will be modified to reflect the process and ensure compliance.

Recommendation 2. We recommended that the facility ensure that licensed independent practitioners' folders do not contain licensure verification information.

Concur

Target date for completion: June 30, 2015

Facility response: The Credentialing and Privileging Coordinator is in the process of removing all licensure verification information from licensed independent practitioners' folders and assuring the information is appropriately scanned into VetPro. This will be completed by March 31, 2015. Beginning in April 2015, quality management will review a random sample of ten licensed independent practitioners' folders monthly to assure that they do not contain licensure verification information. Target is 100 percent for three consecutive months to assure sustained compliance. Local policy will be modified to agree with the process and ensure compliance.

Recommendation 3. We recommended that the facility establish a committee to provide oversight of the safe patient handling program.

Concur

Target date for completion: November 2014 (completed)

Facility response: The Safe Patient Handling Work Group is responsible for oversight of the Safe Patient Handling Program including reviewing, tracking and analyzing patient handling injury data, safety issues related to safe patient handling equipment, and the education and training of staff for safe patient handling equipment. The Safe Patient Handling Work Group is meeting on a regular basis and reports to the Accident Review Board and the Environment of Care Committee as appropriate.

Recommendation 4. We recommended that the quality control policy/process for scanning include an alternative means of capturing data when the quality of the source document does not meet image quality controls, a complete review of scanned documents to ensure retrievability, and quality assurance reviews on a sample of the scanned documents.

Concur

Target date for completion: Completed

Facility response: Scanning policy has been modified to include alternative for capturing data. When documents are unable to meet quality control for scanning, the requesting clinician is alerted to the problem and they may choose to summarize the information in a progress note. Quality checks for retrievability are being done on a sample of total work completed by health information management service staff. Quality check information will be forwarded to the Medical Records Committee.

Recommendation 5. We recommended that Environment of Care Committee minutes reflect sufficient detail regarding corrective actions for identified deficiencies and track corrective actions to closure.

Concur

Target date for completion: June 30, 2015

Facility response: Beginning with the February 2015 Environment of Care Committee meeting, the subject of meeting minutes will be added to the meeting agenda. One committee member (Quality Management staff) has been designated to ensure adequate detail is captured and that corrective actions are tracked.

Recommendation 6. We recommended that the facility repair damaged floors and walls in patient care areas.

Concur

Target date for completion: April 6, 2015

Facility response: The facility has established a working committee with a membership comprised of representatives from facility management service, medical staff, safety, unions, senior management, as well as other departments on an as-needed basis, to develop and implement a plan for inspecting all patient care areas

to identify damage to floor and wall surfaces requiring corrective action. The committee will conduct a detailed inspection of all patient areas and issue an initial report of their findings by April 6, 2015.

Work orders to correct minor deficiencies will be issued as they are identified. The status of the work orders will be reported to Environment of Care Committee and to senior management on a monthly basis.

Projects to correct major deficiencies (i.e., deficiencies requiring the services of an outside contractor(s) will be issued to Contracting by the end of FY 15.

Recommendation 7. We recommended that the facility repair or replace damaged furnishings, plumbing fixtures, and windows in patient care areas.

Concur

Target date for completion: April 6, 2015

Facility response: The facility has established a working committee with a membership comprised of representatives from facility management service, medical staff, safety, unions, senior management, as well as other departments on an as-needed basis, to develop and implement a plan for inspecting all patient care areas to repair or replace damaged furnishings, plumbing fixtures, and windows in patient care areas. The committee will conduct a detailed inspection of all patient areas and issue an initial report of their findings by April 6, 2015.

Work orders to correct minor deficiencies will be issued as they are identified. The status of the work orders will be reported to Environment of Care Committee and to senior management on a monthly basis.

Projects to correct major deficiencies (i.e., deficiencies requiring the services of an outside contractor(s) will be issued to Contracting by the end of FY 15.

Recommendation 8. We recommended that all required Environment of Care Committee members consistently attend committee meetings and that facility managers monitor compliance.

Concur

Target date for completion: June 30, 2015

Facility response: Beginning with the February 2015 Environment of Care Committee meeting, the subject of membership and attendance will be added to the meeting agenda. Members are required to send delegates in the event of planned absences. Unexcused absences will be addressed through supervisory channels. Monitoring will be accomplished monthly, with a goal of 85 percent or greater attendance of committee members for a three-month period.

Recommendation 9. We recommended that the facility conduct and document annual complete system checks of the community living center's elopement prevention system and that facility managers monitor compliance.

Concur

Target date for completion: June 5, 2015

Facility response: A procedure to require, and document the results of, annual testing of the CLC elopement prevention system will be issued by May 15, 2015. The first annual test will be completed by June 5, 2015.

Recommendation 10. We recommended that the facility revise the policy for safe use of automated dispensing machines to include oversight of overrides and employee training and minimum competency requirements for users.

Concur

Target date for completion: April 30, 2015

Facility response: The medical center policy related to safe use of automated dispensing machines is under revision by the Pharmacy Manager to include oversight of overrides and to address employee training and minimum competency requirements for users. It is expected that the policy will be completed and approved by April 30, 2015.

Recommendation 11. We recommended that Mental Health Service's Automated Data Processing Applications Coordinators provide training in the use of the computerized consult package and that facility managers monitor compliance.

Concur

Target date for completion: March 31, 2015

Facility response: Although this is considered to be an Automated Data Processing Applications Coordinator function, as designated in local facility policy, the Mental Health Service Line Manager has chosen to alternatively add this responsibility to the Mental Health Program Managers to provide training in the use of the computerized consult package and to monitor compliance. Mental Health Program Managers will provide refresher training to inpatient staff at the next scheduled Mental Health Staff Meeting. Training in the use of computerized consults will be added to the Mental Health new employee orientation and training. A quarterly review will be conducted to verify that the consult training has been completed for new employees. The facility will consider revising the policy to agree with the change in practice

Recommendation 12. We recommended that requestors consistently select the proper consult title and that facility managers monitor compliance.

Concur

Target date for completion: March 31, 2015

Facility response: Training will be provided for inpatient staff at the next mental health staff meeting and for all new employees who are responsible for entering consults related to consult selection for inpatients.

Monitor will include random sample of 10 records per month of patients who are admitted to the acute psychiatric unit and have consults written for the evidence of use of correct selection. Monitoring will continue until target of 90 percent or higher is achieved for a period of three months.

Recommendation 13. We recommended that consultants do not change the consult request status for inappropriate reasons and that facility managers monitor compliance.

Concur

Target date for completion: June 30, 2015

Facility response: Mental Health Program Managers will provide refresher training to inpatient staff at the next mental health staff meeting and training in the use of computerized consults will be added to the mental health new employee orientation and training. Monitor will include appropriateness of consult status for patients who are hospitalized on the Acute Psychiatric Unit/ward 4L. A random sample of 10 inpatient consults per month will be reviewed to ensure that the type of consult (inpatient or outpatient) was correct. We will continue to monitor until 90 percent compliance is sustained for at least three months.

Office of Inspector General
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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 2010-052, *Management of Wandering and Missing Patients*, December 3, 2010.
- VHA Directive 2011-007, *Required Hand Hygiene Practices*, February 16, 2011.
- Under Secretary for Health, "Non-Research Animals in Health Care Facilities," Information Letter 10-2009-007, June 11, 2009.
- Various requirements of The Joint Commission, the Occupational Safety and Health Administration, the International Association of Healthcare Central Service Materiel Management, the National Fire Protection Association, the Health Insurance Portability and Accountability Act, Underwriters Laboratories.

[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 2012-032, *Out of Operating Room Airway Management*, October 26, 2012.
- VHA Handbook 1101.04, *Medical Officer of the Day*, August 30, 2010.