Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 15-04697-105

Combined Assessment Program Review of the Sheridan VA Healthcare System Sheridan, Wyoming

February 10, 2016

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

AD	advance directive
CAP	Combined Assessment Program
CSP	compounded sterile product
CT	computed tomography
EHR	electronic health record
EOC	environment of care
facility	Sheridan VA Healthcare System
FY	fiscal year
HPC	hospice and palliative care
MH	mental health
NA	not applicable
NM	not met
OIG	Office of Inspector General
OR	operating room
QSV	quality, safety, and value
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 November 2, 2015.

Review Results: The review covered seven activities and two follow-up review areas from the previous Combined Assessment Program review. We made no recommendations in the following three activities:

- Medication Management
- Computed Tomography Radiation Monitoring
- Advanced Directives

The facility's reported accomplishments were the continuation of their annual community outreach program focusing on women veterans' health issues and the implementation of a support group for the lesbian, gay, bisexual, and transgender veteran community.

Recommendations: We made recommendations in the following four activities and two follow-up review areas:

Quality, Safety, and Value: Review Ongoing Professional Practice Evaluation data biannually. Ensure Physician Utilization Management Advisors document their decisions in the National Utilization Management Integration database. Consistently take actions when data analyses indicate problems or opportunities for improvement and evaluate them for effectiveness in committee reviews, utilization management, and root cause analyses.

Environment of Care: Conduct an annual infection prevention risk assessment. Ensure all dental clinic employees complete bloodborne pathogens training annually.

Coordination of Care: Revise the patient discharge policy to include scheduling discharges early in the day. Revise the temporary bed locations policy to include all required elements. Ensure sending nurses document transfer assessments.

Suicide Prevention Program: Consistently place Patient Record Flags in the electronic health records of patients identified as high risk for suicide, and do not place them in the electronic health records of patients identified as moderate or low risk for suicide. Include in Suicide Prevention Safety Plans the identification of assessment of available lethal means and how to keep the environment safe.

Follow-Up on Quality Management: Ensure electronic health record quality reviews include a representative sample of charts from each service or program.

Follow-Up on Coordination of Care: Ensure all non-hospice and palliative care clinical staff who provide care to patients at the end of their lives receive end-of-life training. Establish a process to track and document hospice and palliative care consults that are not acted upon within 7 days of the request.

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 26–32, for the full text of the Directors' comments.) We consider recommendations 4 and 5 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 seven activities and two follow-up review areas from the previous CAP review:

- QSV
- EOC
- Medication Management
- Coordination of Care
- CT Radiation Monitoring
- ADs
- Suicide Prevention Program
- Follow-Up on Quality Management
- Follow-Up on Coordination of Care

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, FY 2015, and FY 2016 through November 6, 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 Sheridan VA Healthcare System, Sheridan, Wyoming*, Report No. 13-01671-262, August 9, 2013). We made repeat recommendations in quality management and coordination of care.

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 164 responses. We shared summarized results with the Facility Director.

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

Promoting Our Women Warriors of Wyoming (P.O.W.W.O.W.)

With a theme of "Grow Where You're Planted," the facility partnered with the Cheyenne VA Medical Center and state Veterans Service Organizations to host the 4th annual Promoting Our Women Warriors of Wyoming (P.O.W.W.O.W.). One hundred and thirty women attended this year's gathering in central Wyoming where they participated in various breakout sessions, which included creating wellness boards, exploring body image, and scrapbooking. There were also nationally known speakers, information booths, and networking opportunities. The event has grown from 88 attendees the first year and includes representation from all service branches. The 2015 event featured women from the Wyoming Veterans Memorial Museum in period era military uniforms interacting with the attendees.

Special Population

The facility provides gender-specific groups and services for lesbian, gay, bisexual, and transgender individuals and male and female military sexual trauma populations. The facility provides residential treatment facility Cognitive Processing Therapy for both populations; two women-only military sexual trauma groups; and one lesbian, gay, bisexual, and transgender-only group. The facility is one of two VAs that offer the lesbian, gay, bisexual, and transgender-only group and one of five that offer the women-only group. These two groups have been well received by referring clinicians as well as the veterans who attend the groups.

Results and Recommendations

QSV

The purpose of this review was to determine whether the facility complied with selected QSV program requirements.[a]

We conversed with senior managers and key QSV employees, and we evaluated meeting minutes, 20 licensed independent practitioners' profiles, 10 protected peer reviews, 7 root cause analyses, and other relevant documents. The table below shows the areas reviewed for this topic. The areas marked as NM did not meet applicable requirements and needed improvement. 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 QSV functions that met at least quarterly and was chaired or co-chaired by the Facility Director. • The committee routinely reviewed aggregated data.		
X	Credentialing and privileging processes met selected requirements: • Facility policy/by-laws addressed a frequency for clinical managers to review practitioners' Ongoing Professional Practice Evaluation data. • Facility clinical managers reviewed Ongoing Professional Practice Evaluation data at the frequency specified in the policy/by-laws. • The facility set triggers for when a Focused Professional Practice Evaluation for cause would be indicated. • The facility followed its policy when employees' licenses expired.	• None of the profiles contained evidence that clinical managers reviewed Ongoing Professional Practice Evaluation data biannually.	**1.** We recommended that facility clinical managers review Ongoing Professional Practice Evaluation data biannually and that facility managers monitor compliance.

NM	Areas Reviewed (continued)	Findings	Recommendations
	Protected peer reviews met selected requirements: • Peer reviewers documented their use of important aspects of care in their review such as appropriate and timely ordering of diagnostic tests, timely treatment, and appropriate documentation. • When the Peer Review Committee recommended individual improvement actions, clinical managers implemented the actions.		
X	Utilization management met selected requirements: • The facility completed at least 75 percent of all required inpatient reviews. • Physician Utilization Management Advisors documented their decisions in the National Utilization Management Integration database. • The facility had designated an interdisciplinary group to review utilization management data.	• There was no evidence that Physician Utilization Management Advisors had documented decisions in the National Utilization Management Integration database since September 29, 2015.	**2.** We recommended that Physician Utilization Management Advisors document their decisions in the National Utilization Management Integration database and that facility managers monitor compliance.
	Patient safety met selected requirements: • The Patient Safety Manager entered all reported patient incidents into the WEBSPOT database. • The facility completed the required minimum of eight root cause analyses. • The facility provided feedback about the root cause analysis findings to the individual or department who reported the incident. • At the completion of FY 2015, the Patient Safety Manager submitted an annual patient safety report to facility leaders.		

NM	Areas Reviewed (continued)	Findings	Recommendations
X	Overall, if QSV reviews identified significant issues, the facility took actions and evaluated them for effectiveness.	• The facility did not consistently take actions and evaluate them for effectiveness when QSV reviews identified significant issues in Quality Oversight Board and Medical Executive Board committee reviews, utilization management, and root cause analyses.	**3.** We recommended that the facility consistently take actions when data analyses indicate problems or opportunities for improvement and evaluate them for effectiveness in committee reviews, utilization management, and root cause analyses and that facility managers monitor compliance.
	Overall, senior managers actively participated in QSV activities.		
	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 dental clinic.[b]

We inspected the community living center; inpatient medicine and MH units; and the urgent care, primary care, women's health and dental clinics. Additionally, we reviewed relevant documents, including training and competency files for eight dental clinic employees, 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
	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.		
X	The facility conducted an infection prevention risk assessment.	• The facility did not conduct an annual infection prevention risk assessment.	**4.** We recommended that the facility conduct an annual 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 between patients.		
	The facility conducted required fire drills in buildings designated for health care occupancy and documented drill critiques.		
	The facility had a policy/procedure/guideline for identification of individuals entering the facility, and units/areas complied with requirements.		

NM	Areas Reviewed for General EOC (continued)	Findings	Recommendations
	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.		
	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.		
	Areas Reviewed for Dental Clinic		
X	Dental clinic employees completed bloodborne pathogens training within the past 12 months.	• None of the eight dental clinic employees had documentation of bloodborne pathogens training during the past 12 months.	**5.** We recommended that dental clinic managers ensure all dental clinic employees complete bloodborne pathogens training annually and monitor compliance.
	Dental clinic employees received hazard communication training on chemical classification, labeling, and safety data sheets.		
NA	Designated dental clinic employees received laser safety training in accordance with local policy.		
	The facility tested dental water lines in accordance with local policy.		
	The facility met environmental safety and infection prevention requirements in the dental clinic.		.
NA	The facility met laser safety requirements in the dental clinic.		
	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.		

NM	Areas Reviewed for the OR	Findings	Recommendations
NA	The facility had emergency fire policy/procedures for the OR that included alarm activation, evacuation, and equipment shutdown with responsibility for turning off room or zone oxygen.		
NA	The facility had cleaning policy/procedures for the OR and adjunctive areas that included a written cleaning schedule and methods of decontamination.		
NA	OR housekeepers received training on OR cleaning/disinfection in accordance with local policy.		
NA	The facility monitored OR temperature, humidity, and positive pressure.		
NA	The facility met fire safety requirements in the OR.		
NA	The facility met environmental safety requirements in the OR.		
NA	The facility met infection prevention requirements in the OR.		
NA	The facility met medication safety and security requirements in the OR.		
NA	The facility met laser safety requirements in the OR.		
NA	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 facility complied with selected requirements for the safe preparation of CSPs.[c]

We reviewed relevant documents and the competency assessment/testing records of 19 employees (9 pharmacy employees and 10 nursing employees who routinely compound non-emergent sterile products). Additionally, we inspected one area where sterile products are compounded. 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 policy on preparation of CSPs that included required components: • Pharmacist CSP preparation or supervision of preparation except in urgent situations • Hazardous CSP preparation in an area separate from routine CSP preparation or in a compounding aseptic containment isolator • Environmental quality and control of ante and buffer areas • Hood certification initially and every 6 months thereafter • Cleaning procedures for all surfaces in the ante and buffer areas		
	The facility established competency assessment requirements for employees who prepare CSPs that included required elements, and facility managers assessed employee competency at the required frequency based on the facility's risk level.		

NM	Areas Reviewed (continued)	Findings	Recommendations
NA	If the facility used an outsourcing facility for CSPs, it had a policy/guidelines/a plan that included required components for the outsourcing facility: • Food and Drug Administration registration • Current Drug Enforcement Agency registration if compounding controlled substances		
	The facility had a safety/competency assessment checklist for preparation of CSPs that included required steps in the proper order to maintain sterility.		
	All International Organization for Standardization classified areas had documented evidence of periodic surface sampling, and the facility completed required actions when it identified positive cultures.		
	The facility had a process to track and report CSP medication errors, including near misses.		
	The facility met design and environmental safety controls in compounding areas.		
	The facility used a laminar airflow hood or compounding aseptic isolator for preparing non-hazardous intravenous admixtures and any sterile products.		
NA	The facility used a biological safety cabinet in a physically separated negative pressure area or a compounding aseptic containment isolator for hazardous medication compounding and had sterile chemotherapy type gloves available for compounding these medications.	.	

NM	Areas Reviewed (continued)	Findings	Recommendations
NA	If the facility prepared hazardous CSPs, a drug spill kit was available in the compounding area and during transport of the medication to patient care areas.		
NA	Hazardous CSPs were physically separated or placed in specially identified segregated containers from other inventory to prevent contamination or personnel exposure.		
NA	An eyewash station was readily accessible near hazardous medication compounding areas, and there was documented evidence of weekly testing.		
	The facility documented cleaning of compounding areas, and employees completed cleaning at required frequencies.		
	During the past 12 months, the facility initially certified new hoods and recertified all hoods minimally every 6 months.		
	Prepared CSPs had labels with required information prior to delivery to the patient care areas: • Patient identifier • Date prepared • Admixture components • Preparer and checker identifiers • Beyond use date		
	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.		

Coordination of Care

The purpose of this review was to evaluate selected aspects of the facility's patient flow process over the inpatient continuum (admission through discharge).[d]

We reviewed relevant documents and conversed with key employees. Additionally, we reviewed the EHRs of 35 randomly selected patients who had an acute care inpatient stay of at least 3 days from July 1, 2014, through June 30, 2015. 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 a policy that addressed patient discharge and scheduling discharges early in the day.	• The facility's discharge/aftercare planning policy did not address scheduling patient discharges early in the day.	**6.** We recommended that the facility revise its policy for patient discharge to include scheduling discharges early in the day.
X	The facility had a policy that addressed temporary bed locations, and it included: • Priority placement for inpatient beds given to patients in temporary bed locations • Upholding the standard of care while patients are in temporary bed locations • Medication administration • Meal provision	• The facility's diversion of patients policy that addresses temporary bed locations did not include: o Priority placement for inpatient beds given to patients in temporary bed locations o Upholding the standard of care while patients are in temporary bed locations o Medication administration o Meal provision	**7.** We recommended that the facility revise its policy for temporary bed locations to include priority placement for inpatient beds given to patients in temporary bed locations, upholding the standard of care while patients are in temporary bed locations, medication administration, and meal provision.
	The Facility Director had appointed a Bed Flow Coordinator with a clinical background.		
	Physicians or acceptable designees completed a history and physical exam within 1 day of the patient's admission or referenced a history and physical exam completed within 30 days prior to admission. • When resident physicians completed the history and physical exams, the attending physicians provided a separate admission note or addendum within 1 day of the admission.		

NM	Areas Reviewed (continued)	Findings	Recommendations
	• When the facility policy and/or scopes of practice allowed for physician assistants or nurse practitioners to complete history and physical exams, they were properly documented.		
	Nurses completed admission assessments within 1 day of the patient's admission.		
	When patients were transferred during the inpatient stay, physicians or acceptable designees documented transfer notes within 1 day of the transfer. • When resident physicians wrote the transfer notes, attending physicians documented adequate supervision. • Receiving physicians documented transfers.		
X	When patients were transferred during the inpatient stay, sending and receiving nurses completed transfer notes.	• For 2 of the 17 applicable EHRs, sending nurses did not document transfer assessments.	**8.** We recommended that sending nurses document transfer assessments and that facility managers monitor compliance.
	Physicians or acceptable designees documented discharge progress notes or instructions that included patient diagnoses, discharge medications, and follow-up activity levels. • When resident physicians completed the discharge notes/instructions, attending physicians documented adequate supervision. • When facility policy and/or scopes of practice allowed for physician assistants or nurse practitioners to complete discharge notes/instructions, they were properly documented.		

NM	Areas Reviewed (continued)	Findings	Recommendations
	Clinicians provided discharge instructions to patients and/or caregivers and documented patients and/or caregiver understanding.		
	The facility complied with 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 five CT technologists and CT scanner inspection reports, and conversed with key managers and employees. We also reviewed the EHRs of 50 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		

NM	Areas Reviewed (continued)	Findings	Recommendations
	A radiologist and technologist expert in CT reviewed all CT protocols revised during the past 12 months.		
	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 32 randomly selected patients who had an acute care admission July 1, 2014, through June 30, 2015. 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 an AD policy that addressed: • AD notification, screening, and discussions • Proper use of AD note titles		
	Employees screened inpatients to determine whether they had ADs and used appropriate note titles to document screening.		
	When patients provided copies of their current ADs, employees had scanned them into the EHR. • Employees correctly posted patients' AD status.		
	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.		
	The facility met any additional elements required by VHA or local policy.		

Suicide Prevention Program

The purpose of this review was to evaluate the extent the facility's MH providers consistently complied with selected suicide prevention program requirements.[g]

We reviewed relevant documents and conversed with key employees. Additionally, we reviewed the EHRs of 40 patients assessed to be at high risk for suicide during the period July 1, 2014–June 30, 2015, plus those who died from suicide during this same timeframe. We also reviewed the training records of 15 new 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 full-time Suicide Prevention Coordinator.		
	The facility had a process for responding to referrals from the Veterans Crisis Line and for tracking patients who are at high risk for suicide.		
	The facility had a process to follow up on high-risk patients who missed MH appointments.		
	The facility provided training within required timeframes: • Suicide prevention training to new employees • Suicide risk management training to new clinical employees		
	The facility provided at least five suicide prevention outreach activities to community organizations each month.		
	The facility completed required reports and reviews regarding patients who attempted or completed suicide.		
	Clinicians assessed patients for suicide risk at the time of admission.		

NM	Areas Reviewed (continued)	Findings	Recommendations
X	Clinicians appropriately placed Patient Record Flags: • High-risk patients received Patient Record Flags. • Moderate- and low-risk patients did not receive Patient Record Flags.	• Clinicians had not placed flags in the EHRs of 2 of 11 patients identified as high risk for suicide. • Clinicians had placed flags in the EHRs of 17 of 29 patients identified as moderate or low risk for suicide.	**9.** We recommended that clinicians consistently place flags in the electronic health records of patients identified as high risk for suicide and that facility managers monitor compliance. **10.** We recommended that clinicians not place flags in the electronic health records of patients identified as moderate or low risk for suicide and that facility managers monitor compliance.
X	Clinicians documented Suicide Prevention Safety Plans that contained the following required elements: • Identification of warning signs • Identification of internal coping strategies • Identification of contact numbers of family or friends for support • Identification of professional agencies • Assessment of available lethal means and how to keep the environment safe	• Sixteen of 29 safety plans lacked documentation of the identification of assessment of available lethal means and how to keep the environment safe.	**11.** We recommended that clinicians include the identification of assessment of available lethal means and how to keep the environment safe in Suicide Prevention Safety Plans and that facility managers monitor compliance.
	Clinicians documented that they gave patients and/or caregivers a copy of the safety plan.		
	The treatment team evaluated patients as follows: • At least four times during the first 30 days after discharge. • Every 90 days to review Patient Record Flags.		
	The facility complied with any additional elements required by VHA or local policy.		

Review Activities with Previous CAP Recommendations

Follow-Up on Quality Management

As a follow-up to a recommendation from our previous CAP review, we reassessed facility compliance with EHR quality reviews.[h]

EHR Entries. VHA requires that EHR quality reviews include a representative sample of charts from each service or program, inpatient and outpatient. There was no evidence that the facility's EHR quality reviews included social work and psychiatry.

Recommendation

12. We recommended that facility managers ensure electronic health record quality reviews include a representative sample of charts from each service or program.

Follow-Up on Coordination of Care

As a follow-up to recommendations from our previous CAP review, we reassessed facility compliance with selected requirements related to HPC, including the Palliative Care Consult Team, consults, and inpatient services.[i]

End-of-Life Training. VHA requires that all staff who provide care to patients at the end of their lives complete training on the unique needs of dying patients and their families. At the time of the previous CAP review, four non-HPC clinical staff had not completed the required training. In response to this finding, the HPC Committee instituted mandatory new end-of-life training in 2014. However, the training was not assigned as mandatory training for designated employees in the Talent Management System and therefore was not completed by any employees required to have the training.

HPC Consults. VHA requires that facilities establish procedures to track HPC clinical consultation requests to ensure all requests are acted upon within 7 days. The facility identified that their previous way of tracking HPC consults not acted upon within 7 days and documentation of tracking were inefficient. At the time of this review, the facility had discontinued documenting and tracking HPC consults.

Recommendations

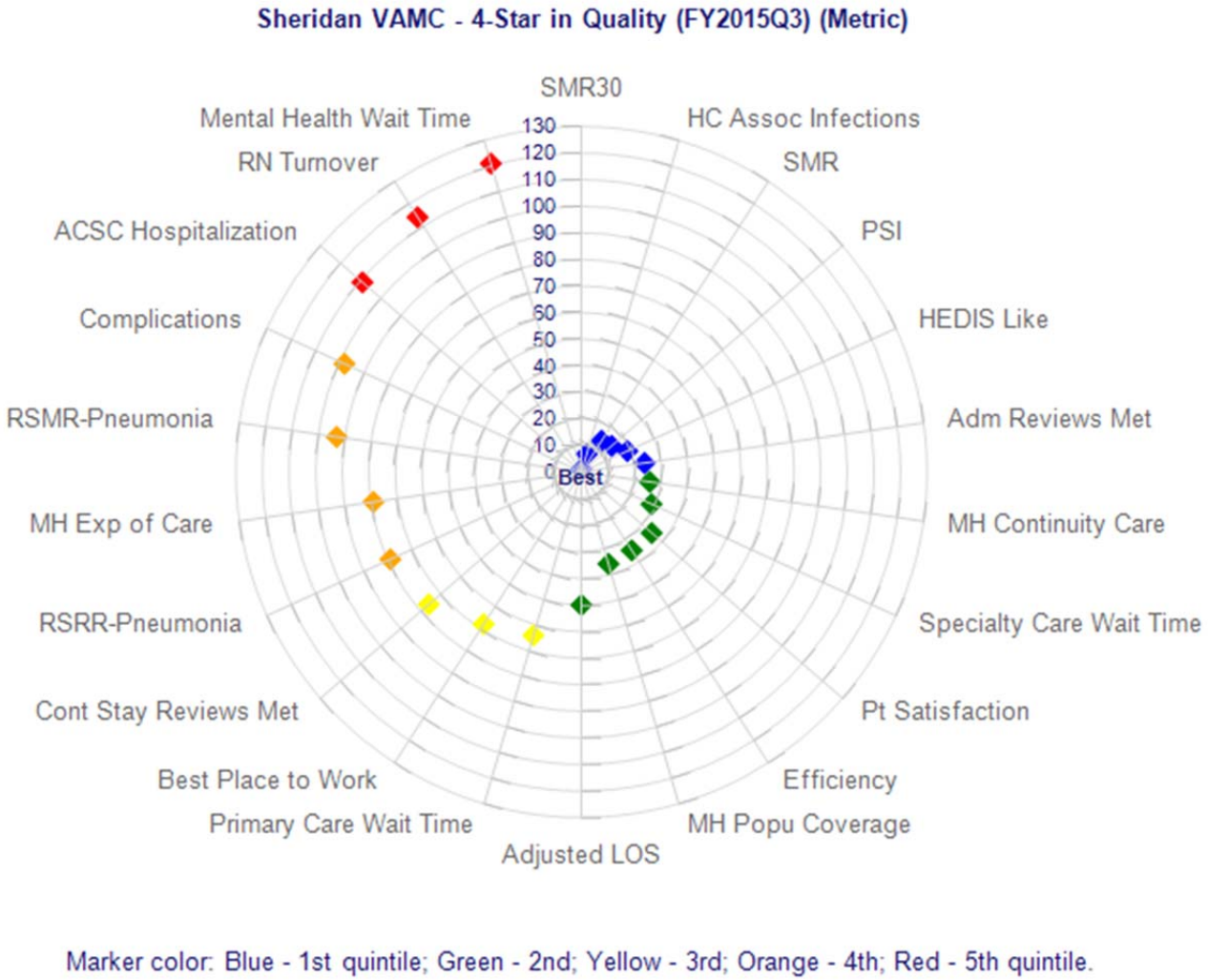
13. We recommended that facility managers ensure all non-hospice and palliative care clinical staff who provide care to patients at the end of their lives receive end-of-life training.

14. We recommended that facility managers establish a process to track and document hospice and palliative care consults that are not acted upon within 7 days of the request.

Facility Profile (Sheridan/666) FY 2016 through November 2015[1]	
Type of Organization	Secondary
Complexity Level	3 – Low complexity
Affiliated/Non-Affiliated	Affiliated
Total Medical Care Budget in Millions	$17.3
Number (as of December 7, 2015) of:	
• **Unique Patients**	6,786
• **Outpatient Visits**	19,155
• **Unique Employees**[2]	474
Type and Number of Operating Beds:	
• **Hospital**	60
• **Community Living Center**	40
• **MH**	85
Average Daily Census:	
• **Hospital**	31
• **Community Living Center**	31
• **MH**	46
Number of Community Based Outpatient Clinics	8
Location(s)/Station Number(s)	Casper/666GB Riverton/666GC Powell/666GD Gillette/666GE Rock Springs/666GF Afton/666QA Evanston/666QB Worland/666QC
Veterans Integrated Service Network Number	19

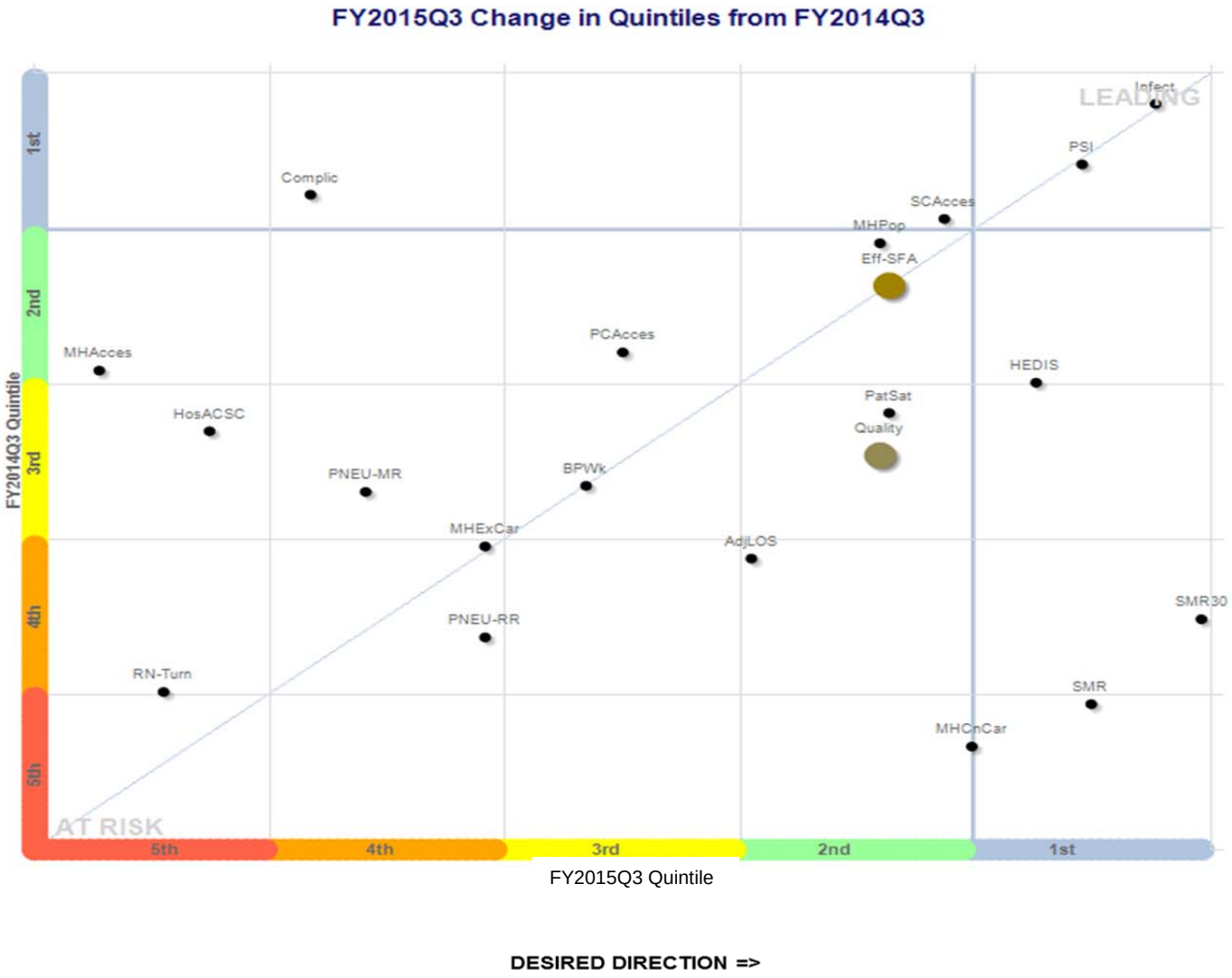
[1] All data is for FY 2016 through November 2015 except where noted.
[2] Unique employees involved in direct medical care (cost center 8200).

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 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

Appendix C

Veterans Integrated Service Network Director Comments

Department of Veterans Affairs

Memorandum

Date: December 22, 2015

From: Director, Rocky Mountain Network (10N19)

Subject: **CAP Review of the Sheridan VA Healthcare System, Sheridan, WY**

To: Director, Seattle Office of Healthcare Inspections (54SE)

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

I have reviewed and concur on the response from the Sheridan VAHCS to the draft CAP Review of their facility. If you have any questions, please contact Ms. Ruth Hammond, VISN 19 Quality Management Specialist at (303) 639-7016.

Ralph T. Gigliotti, FACHE

Facility Director Comments

Department of Veterans Affairs

Memorandum

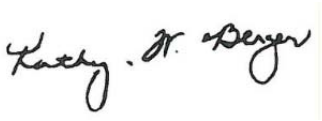
Date: December 18, 2015

From: Director, Sheridan VA Healthcare System (666/00)

Subject: **CAP Review of the Sheridan VA Healthcare System, Sheridan, WY**

To: Director, Rocky Mountain Network (10N19)

1. After reviewing this report, I concur with the identified findings.
2. The Sheridan VA Healthcare System developed and implemented the following action plans with designated anticipated completion dates.
3. If you have any questions or would like to discuss this response, please contact me at 307-675-3530.



Kathy W. Berger

Comments to OIG's Report

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

OIG Recommendations

Recommendation 1. We recommended that facility clinical managers review Ongoing Professional Practice Evaluation data biannually and that facility managers monitor compliance.

Concur

Target date for completion: July 1, 2016

Facility response: Communication of the January–June 2015 Ongoing Professional Practice Evaluation (OPPE) was completed and the July–December 2015 OPPE review is slated for completion and reporting to the Executive Committee of the Medical Staff (ECOMS) in January 2016. In order to ensure the continued timely receipt, review and communication of OPPE data, the Chief of Staff's Office provided the services additional tools with an expectation that the data will be gathered monthly, analyzed and reviewed with providers quarterly and reported to ECOMS semiannually.

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

Concur

Target date for completion: March 31, 2016

Facility response: Physician Utilization Management Advisors (PUMAs) are fully trained and aware of their responsibility for completing documentation in the National Utilization Management Integration (NUMI) database. Monthly data will be reviewed by the Medical Executive Board (MEB) to ensure improvement sustained by the PUMAs.

Recommendation 3. We recommended that the facility consistently take actions when data analyses indicate problems or opportunities for improvement and evaluate them for effectiveness in committee reviews, utilization management, and root cause analyses and that facility managers monitor compliance.

Concur

Target date for completion: July 1, 2016

Facility response: To ensure opportunities for improvement identified in data analysis and in committees have documented actions, the facility template for meeting minutes was updated to ensure action items are documented for each topic discussed. In-person education for each committee chair and secretary is planned to reinforce the necessity of action item identification, evaluation of effectiveness, follow-up and close out in meeting minutes. Monthly monitoring of meeting minutes will occur with a report by the Quality Manger to the Executive Leadership Board to ensure processes are well-established.

Recommendation 4. We recommended that the facility conduct an annual infection prevention risk assessment.

Concur

Target date for completion: Completed

Facility response: The facility completed a numerically scored infection prevention risk assessment for 2016 that was reviewed and approved by the facility Infection Control Committee during the December meeting.

Recommendation 5. We recommended that dental clinic managers ensure all dental clinic employees complete bloodborne pathogens training annually and monitor compliance.

Concur

Target date for completion: Completed

Facility response: Occupational Safety and Health Administration-approved bloodborne pathogen (BBP) training was identified in the Talent Management System (TMS), assigned to all employees and will automatically reoccur annually. All eight of the Dental staff have since completed the BBP training.

Recommendation 6. We recommended that the facility revise its policy for patient discharge to include scheduling discharges early in the day.

Concur

Target date for completion: February 1, 2016

Facility response: The local policy, MCM 11-29, Diversion of Patients, will be updated to include the recommendation for providers to schedule discharges early in the day.

Recommendation 7. We recommended that the facility revise its policy for temporary bed locations to include priority placement for inpatient beds given to patients in temporary bed locations, upholding the standard of care while patients are in temporary bed locations, medication administration, and meal provision.

Concur

Target date for completion: February 1, 2016

Facility response: The local policy, MCM 11-29, Diversion of Patients, will be updated to include priority placement for inpatient beds given to patients in temporary bed locations, upholding the standard of care while patients are in temporary bed locations, medication administration, and meal provision.

Recommendation 8. We recommended that sending nurses document transfer assessments and that facility managers monitor compliance.

Concur

Target date for completion: March 31, 2016

Facility response: A visual aid was developed and nursing education completed to remind sending nurses of the requirement to document intra-facility transfer assessments. All intra-facility transfers will be monitored for three months to ensure sustained compliance at 90% or above and quarterly thereafter to ensure processes are well-established.

Recommendation 9. We recommended that clinicians consistently place flags in the electronic health records of patients identified as high risk for suicide and that facility managers monitor compliance.

Concur

Target date for completion: March 31, 2016

Facility response: To aid with the ease of identification of Veterans at high risk for suicide, the facility is modifying the tool used to assign level of risk. Those patients designated as at high- and eminent- risk will consistently receive a high-risk flag. Risk assessments and associated high-risk flags will be monitored for three months to ensure sustained compliance at 90% or above and quarterly thereafter to ensure processes are well-established.

Recommendation 10. We recommended that clinicians not place flags in the electronic health records of patients identified as moderate or low risk for suicide and that facility managers monitor compliance.

Concur

Target date for completion: March 31, 2016

Facility response: To aid with the ease of identification of Veterans at high risk for suicide, the facility is modifying the tool used to assign level of risk. Those patients designated as at no-, low- and moderate- risk will not receive a high-risk flag. Risk assessments and associated high-risk flags will be monitored for three months to ensure sustained compliance at 90% or above and quarterly thereafter to ensure processes are well-established.

Recommendation 11. We recommended that clinicians include the identification of assessment of available lethal means and how to keep the environment safe in Suicide Prevention Safety Plans and that facility managers monitor compliance.

Concur

Target date for completion: March 31, 2016

Facility response: To help clearly define the Suicide Prevention Safety Plan requirements for the identification and assessment of available lethal means and how to keep the environment safe, the facility is enhancing the national template. Staff education will reinforce the identification and assessment of available lethal means and how to keep the environment safe. Suicide Prevention Safety Plans will be monitored for three months to ensure sustained compliance at 90% or above and quarterly thereafter to ensure processes are well-established.

Recommendation 12. We recommended that facility managers ensure electronic health record quality reviews include a representative sample of charts from each service or program.

Concur

Target date for completion: July 1, 2016

Facility response: The Clinical Informatics and Medical Records Committee (CIMR) established a subgroup to determine record reviews currently occurring in each service and program in order to ensure all areas are represented. These areas will report data, analysis of the data and any necessary actions to CIMR quarterly.

Recommendation 13. We recommended that facility managers ensure all non-hospice and palliative care clinical staff who provide care to patients at the end of their lives receive end-of-life training.

Concur

Target date for completion: March 31, 2016

Facility response: Hospice and Palliative Care training was identified in the Talent Management System (TMS) assigned to all clinical employees and will automatically reoccur annually. TMS will be monitored for three months to ensure sustained compliance at 90% or above.

Recommendation 14. We recommended that facility managers establish a process to track and document hospice and palliative care consults that are not acted upon within 7 days of the request.

Concur

Target date for completion: February 1, 2016

Facility response: The Hospice and Palliative Care Committee implemented a process whereby they "receive" all new consults at their weekly meeting utilizing VistA as a double-check to ensure all consults are captured and acted upon within seven days of the request. Additionally, the team updates their Hospice and Palliative Care database on a weekly basis with the new and progress on previous consults. This will be monitored for three months to ensure sustained compliance at 90% or above.

Office of Inspector General
Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the OIG at (202) 461-4720.
Inspection Team	Carol Lukasewicz, RN, BSN, Team Leader Craig Byer, MS, R.R.A. Sarah Mainzer, BSN, JD Sami O'Neill, MA Monika Spinks, RN, BSN
Other Contributors	Elizabeth Bullock Shirley Carlile, BA Paula Chapman, CTRS Lin Clegg, PhD Marnette Dhooghe, MS Marc Lainhart, BS Julie Watrous, RN, MS Jarvis Yu, MS

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U.S. Senate: John Barrasso, Michael B. Enzi
U.S. House of Representatives: Cynthia M. Lummis

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

Endnotes

[a] References used for this topic were:
- VHA Directive 1026, *VHA Enterprise Framework for Quality, Safety, and Value*, August 2, 2013.
- VHA Directive 1117, *Utilization Management Program*, July 9, 2014.
- VHA Directive 2010-025, *Peer Review for Quality Management*, June 3, 2010.
- VHA Handbook 1050.01, *VHA National Patient Safety Improvement Handbook*, March 4, 2011.
- VHA Handbook 1100.19, *Credentialing and Privileging*, October 15, 2012.

[b] References used for this topic included:
- VHA Directive 2005-037, *Planning for Fire Response*, September 2, 2005.
- VHA Directive 2009-026; *Location, Selection, Installation, Maintenance, and Testing of Emergency Eyewash and Shower Equipment*; May 13, 2009.
- 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, National Fire Protection Association, Association of periOperative Registered Nurses, U.S. Pharmacopeial Convention, American National Standards Institute.

[c] References used for this topic included:
- VHA Handbook 1108.06, *Inpatient Pharmacy Services*, June 27, 2006.
- VHA Handbook 1108.07, *Pharmacy General Requirements*, April 17, 2008.
- Various requirements of VA Pharmacy Benefits Management Services, The Joint Commission, the United States Pharmacopeial Convention, the American Society of Health-System Pharmacists, the Institute for Safe Medication Practices, the Food and Drug Administration, and the American National Standards Institute.

[d] The references used for this topic included:
- VHA Directive 1009, *Standards for Addressing the Needs of Patients Held in Temporary Bed Locations*, August 28, 2013.
- VHA Directive 1063, *Utilization of Physician Assistants (PA)*, December 24, 2013.
- VHA Handbook 1400.01, *Resident Supervision*, December 19, 2012.
- VHA Handbook 1907.01, *Health Information Management and Health Records*, March 19, 2015.

[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 2010-025, *Peer Review for Quality Management*, June 3, 2010.
- VHA Directive 2010-053, *Patient Record Flags*, December 3, 2010 (corrected 2/3/11).
- VHA Handbook 1050.01, *VHA National Patient Safety Improvement Handbook*, March 4, 2011.
- VHA Handbook 1160.01, *Uniform Mental Health Services in VA Medical Centers and Clinics*, September 11, 2008.
- VHA Handbook 1160.06, *Inpatient Health Services*, September 16, 2013.
- Various Deputy Under Secretary for Health for Operations and Management memorandums and guides.
- *VA Suicide Prevention Coordinator Manual*, August 2014.
- Various requirements of The Joint Commission.

[h] The reference used for this topic was:
- VHA Handbook 1907.01, *Health Information Management and Health Records*, March 19, 2015.

[i] The references used for this topic were:
- VHA Directive 2008-056, *VHA Consult Policy*, September 16, 2008.
- VHA Directive 2008-066, *Palliative Care Consult Team*, October 23, 2008.
- The Veterans' Health Care Eligibility Reform Act of 1996.