Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 15-04704-297

Combined Assessment Program Review of the Northern Arizona VA Health Care System Prescott, Arizona

May 12, 2016

Washington, DC 20420

To Report Suspected Wrongdoing in VA Programs and Operations
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Glossary

AD	advance directive
CAP	Combined Assessment Program
CS	controlled substances
CSP	compounded sterile product
CT	computed tomography
EHR	electronic health record
EOC	environment of care
facility	Northern Arizona VA Health Care System
FY	fiscal year
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 16, 2015, and December 29–30, 2015.

Review Results: The review covered eight activities and three follow-up review areas from the previous Combined Assessment Program review. The facility's reported accomplishment was receiving the VA National Center for Patient Safety's Gold Cornerstone Award for fiscal year 2015.

Recommendations: We made recommendations in all the following eight activities and three follow-up review areas:

Quality, Safety, and Value: Review Ongoing Professional Practice Evaluation data semi-annually.

Environment of Care: Ensure patient care areas and furnishings and equipment in patient care areas are clean. Repair damaged furnishings and equipment in patient care areas, or remove them from service.

Medication Management: Consistently monitor temperature in the inpatient pharmacy compounding buffer areas. Perform and document monthly cleaning of storage shelving in all compounding areas. Certify all hoods at least every 6 months.

Coordination of Care: Develop a temporary bed location policy. Appoint a Bed Flow Coordinator with a clinical background. Consistently document discharge progress notes or instructions that include all required elements.

Computed Tomography Radiation Monitoring: Develop a computed tomography policy and procedures that include all required components. Ensure all computed tomography technologists have documented annual radiation safety training.

Advance Directives: Consistently correctly post patients' advance directives status. Ask inpatients whether they would like to discuss creating, changing, and/or revoking advance directives.

Suicide Prevention Program: Ensure new clinical employees complete suicide risk management training within the required timeframe. Provide at least five community outreach activities every month, and maintain documentation of these activities. Consistently assess patients for suicide risk prior to placing a high risk for suicide flag. Do not place flags in the electronic health records of moderate- and low-risk patients. Include in Suicide Prevention Safety Plans the contact numbers of family or friends for support. Ensure patients and/or family members receive a copy of the Suicide Prevention Safety Plan. Review patients' high-risk flags at least every 90 days.

Mammography Services: Establish a mammography services policy. Link mammogram results to the radiology order in the electronic health record. Ensure ordering clinicians receive signed written mammography reports within 30 days of the procedure date.

Follow-Up on Medication Management – Controlled Substances Inspection Program: Provide the Facility Director with controlled substances inspection quarterly trend reports.

Follow-Up on Pressure Ulcer Prevention and Management: Provide pressure ulcer education to patients at risk for or with pressure ulcers and/or their caregivers, and document the education.

Follow-Up on Nurse Staffing: Monitor the staffing methodology implemented in August 2013.

Comments

The Veterans Integrated Service Network Director and Acting Facility Director agreed with the Combined Assessment Program review findings and recommendations and provided acceptable improvement plans. (See Appendixes C and D, pages 29–40, for the full text of the Directors' comments.) We will follow up on the planned actions until they are completed.

JOHN D. DAIGH, JR., M.D.
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Objectives and Scope

Objectives

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

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

Scope

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

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

- QSV
- EOC
- Medication Management
- Coordination of Care
- CT Radiation Monitoring
- ADs
- Suicide Prevention Program
- Mammography Services
- Follow-Up on Medication Management – CS Inspection Program

- Follow-Up on Pressure Ulcer Prevention and Management
- Follow-Up on Nurse Staffing

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 19, 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 Northern Arizona VA Health Care System, Prescott, Arizona,* Report No. 13-02642-21, December 3, 2013). We made repeat recommendations in Medication Management – CS Inspection Program, Pressure Ulcer Prevention and Management, and Nurse Staffing.

During this review, we presented crime awareness briefings for 35 employees. These briefings covered procedures for reporting suspected criminal activity to the OIG and included case-specific examples illustrating procurement fraud, conflicts of interest, and bribery.

Additionally, we surveyed employees regarding patient safety and quality of care at the facility. We distributed an electronic survey to all facility employees and received 320 responses. We shared summarized results with facility managers.

In this report, we make recommendations for improvement. Recommendations pertain to issues that are significant enough for the OIG to monitor until the facility implements corrective actions.

Reported Accomplishment

Cornerstone Recognition Program

The VA National Center for Patient Safety initiated the Cornerstone Recognition Program in 2008 to enhance the root cause analysis process and recognize the accomplishments of patient safety at the facility level. The facility received the Gold Cornerstone Award for FY 2015.

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, 5 root cause analyses, and other relevant documents. The table below shows the areas reviewed for this topic. The area marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

NM	Areas Reviewed	Findings	Recommendations
	There was a senior-level committee responsible for key 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 20 profiles contained evidence that clinical managers reviewed Ongoing Professional Practice Evaluation data semi-annually.	**1.** We recommended that facility clinical managers review Ongoing Professional Practice Evaluation data semi-annually 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.		
	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.		
	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
	Overall, if QSV reviews identified significant issues, the facility took actions and evaluated them for effectiveness.		
	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 cardiology and audiology specialty clinics, acute medicine, telemetry acute care, the dental and primary care clinics, the dementia and hospice/palliative care units in the community living center, and the Emergency Department. Additionally, we reviewed relevant documents and 10 employee training records, and we conversed with key employees and managers. 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 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.		
	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 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.		
	The facility met fire safety requirements.		

NM	Areas Reviewed for General EOC (continued)	Findings	Recommendations
X	The facility met environmental safety requirements.	• Two of eight patient care areas were dirty. • Two of eight patient care areas contained dirty furnishings and/or equipment. • Two of eight patient care areas contained furnishings and/or equipment in need of repair.	**2.** We recommended that facility managers ensure patient care areas and furnishings and equipment in patient care areas are clean and monitor compliance. **3.** We recommended that facility managers initiate actions to repair damaged furnishings and equipment in patient care areas or remove them from service.
	The facility met infection prevention requirements.		
	The facility met medication safety and security requirements.		
	The facility met privacy requirements.		
NA	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.		
	Areas Reviewed for Dental Clinic		
	Dental clinic employees completed bloodborne pathogens training within the past 12 months.		
	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.		

NM	Areas Reviewed for Dental Clinic (continued)	Findings	Recommendations
NA	The facility met laser safety requirements in the dental clinic.		
NA	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.		
	Areas Reviewed for the OR		
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 nine pharmacists. Additionally, we inspected one area where sterile products are compounded. 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 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
	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 CS		
	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.		
X	The facility met design and environmental safety controls in compounding areas.	• There was no evidence of consistent temperature monitoring for the inpatient pharmacy buffer areas.	**4.** We recommended that the facility consistently monitor temperature in the inpatient pharmacy compounding buffer areas and that facility managers monitor compliance.
	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.		
X	The facility documented cleaning of compounding areas, and employees completed cleaning at required frequencies.	• There was no documented evidence of monthly cleaning of storage shelving in the compounding areas.	**5.** We recommended that facility managers ensure employees perform and document monthly cleaning of storage shelving in all compounding areas and monitor compliance.
X	During the past 12 months, the facility initially certified new hoods and recertified all hoods minimally every 6 months.	• For one hood, there was no documented evidence of certifications at least every 6 months during the past 12-month period.	**6.** We recommended that facility managers ensure all hoods are certified at least every 6 months and monitor compliance.
	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
	The facility had a policy that addressed patient discharge and 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 did not have a policy that addressed temporary bed locations.	**7.** We recommended that facility managers develop a temporary bed location policy.
X	The Facility Director had appointed a Bed Flow Coordinator with a clinical background.	• The Facility Director had not appointed a Bed Flow Coordinator.	**8.** We recommended that the Facility Director appoint 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.		
	When patients were transferred during the inpatient stay, sending and receiving nurses completed transfer notes.		
X	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.	• For 10 EHRs (29 percent), physicians did not document a discharge progress note or instructions. • For eight EHRs (23 percent), physician documented discharge progress notes or instructions did not include all required elements.	**9.** We recommended that physicians consistently document discharge progress notes or instructions that include all required elements and that facility managers monitor compliance.

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. 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 designated Radiation Safety Officer responsible for oversight of the radiation safety program.		
X	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	• The facility did not have a CT safety policy or procedures that included: o A CT quality control program o Monitoring CT protocols to ensure they are as low as reasonably achievable o A method for identifying and reporting excessive patient doses for CT to the Radiation Safety Officer o A process for managing/reviewing CT protocols	**10.** We recommended that the facility develop a computed tomography policy and procedures that include all required components.

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.		
X	There was documented evidence that CT technologists had annual radiation safety training and dosimetry monitoring.	• None of the five CT technologists had documented evidence of annual radiation safety training.	**11.** We recommended that the Radiation Safety Officer ensure all computed tomography technologists have documented annual radiation safety training.
NA	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 34 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. 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 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.		
X	When patients provided copies of their current ADs, employees had scanned them into the EHR. • Employees correctly posted patients' AD status.	• For four of the EHRs (12 percent), employees did not correctly post patients' AD status.	**12.** We recommended that employees consistently correctly post patients' advance directives status and that facility managers monitor compliance.
X	Employees asked inpatients if they would like to discuss creating, changing, and/or revoking ADs. • When inpatients requested a discussion, employees documented the discussion and used the required AD note titles.	• Fourteen of the 34 applicable EHRs (41 percent) did not contain documentation that employees asked inpatients whether they wished to discuss creating, changing, and/or revoking ADs.	**13.** We recommended that employees ask inpatients whether they would like to discuss creating, changing, and/or revoking advance directives and that facility managers monitor compliance.
	The facility met any additional elements required by VHA or local policy.		

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 18 patients assessed to be at 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.		
X	The facility provided training within required timeframes: • Suicide prevention training to new employees • Suicide risk management training to new clinical employees	• Seven of the 10 applicable training records indicated that clinicians did not complete suicide risk management training within 90 days of being hired.	**14.** We recommended that facility managers ensure new clinical employees complete suicide risk management training within the required timeframe and monitor compliance.
X	The facility provided at least five suicide prevention outreach activities to community organizations each month.	• The Suicide Prevention Coordinator did not provide evidence of any outreach activities in the 3 months prior to the site visit.	**15.** We recommended that the Suicide Prevention Coordinator provide at least five community outreach activities every month and maintain documentation of these activities and that facility managers monitor compliance.
	The facility completed required reports and reviews regarding patients who attempted or completed suicide.		

NM	Areas Reviewed (continued)	Findings	Recommendations
X	Clinicians assessed patients for suicide risk at the time of admission.	• Three of the 18 applicable EHRs did not contain documentation that clinicians assessed patients for suicide risk at the time they placed high-risk flags in the EHR.	**16.** We recommended that clinicians consistently assess patients for suicide risk prior to placing a high risk for suicide flag and that facility managers monitor compliance.
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 placed flags in the EHRs of five moderate- and/or low-risk patients.	**17.** We recommended that clinicians not place flags in the electronic health records of moderate- and low-risk patients 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	• Five of 11 safety plans lacked documentation of the contact numbers of family or friends for support.	**18.** We recommended that clinicians include the contact numbers of family or friends for support in Suicide Prevention Safety Plans and that facility managers monitor compliance.
X	Clinicians documented that they gave patients and/or caregivers a copy of the safety plan.	• In 3 of 11 EHRs, clinicians did not document that they gave patients and/or caregivers a copy of the plan.	**19.** We recommended that clinicians ensure patients and/or caregivers receive a copy of the Suicide Prevention Safety Plan and that facility managers monitor compliance.
X	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	• Eleven of the 17 applicable EHRs did not contain evidence that the treatment team reviewed patients' high-risk flags at least every 90 days.	**20.** We recommended that treatment teams review patients' high-risk flags at least every 90 days and that facility managers monitor compliance.
	The facility complied with any additional elements required by VHA or local policy.		

Mammography Services

The purpose of this review was to determine whether the facility complied with selected VHA requirements regarding the provision of mammography services for women veterans.[h]

We reviewed relevant documents and the EHRs of 28 women veterans 50–74 years of age who had a screening mammogram July 1, 2014, to June 30, 2015, and we conversed with key managers and employees. The table below shows the areas reviewed for this topic. The areas marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

NM	Areas Reviewed	Findings	Recommendations
X	The facility had a policy addressing mammography services that included required elements.	• The facility did not have a mammography services policy.	**21.** We recommended that facility managers establish a mammography services policy.
	If the facility outsourced mammograms, it defined requirements for turnaround time.		
X	Clinicians linked mammogram results to the radiology order in the EHR.	• Clinicians had not linked mammogram results to the radiology order in any of the EHRs.	**22.** We recommended that clinicians link mammogram results to the radiology order in the electronic health record and that facility managers monitor compliance.
	Mammogram result reports included required elements.		
	Interpreting clinicians reported mammogram results using American College of Radiology codes.		
	The facility sent written summaries of the mammogram results in lay terms to patients within 30 days of the procedure date.		
NA	Clinicians communicated “suspicious” or “highly suggestive of malignancy” results and recommended actions to the patient within 5 business days of the procedure and documented this in the EHR.		

NM	Areas Reviewed (continued)	Findings	Recommendations
	Clinicians communicated incomplete or "probably benign" results to the patient within 14 days from availability of the results and documented this in the EHR.		
X	The facility ensured ordering clinicians received signed written mammography reports within 30 days of the procedure date.	• Twenty-four EHRs did not reflect that ordering clinicians received signed written mammography reports within 30 days of the procedure date.	**23.** We recommended that facility managers ensure ordering clinicians receive signed written mammography reports within 30 days of the procedure date and monitor compliance.
NA	The facility ensured communication of "suspicious" or "highly suggestive of malignancy" results and the recommended course of action to the ordering clinician or responsible designee within 3 business days of the procedure date.		
	The facility designated a full-time Women Veterans Program Manager who was a health care professional with a minimal allotment of clinical time to maintain clinical competency.		
	The facility had established effective mammography oversight processes.		
	The facility complied with any additional elements required by VHA or local policy.		

Review Activities With Previous CAP Recommendations

Follow-Up on Medication Management – CS Inspection Program

As a follow-up to a recommendation from our previous CAP review, we reassessed facility compliance with the Facility Director receiving CS inspection quarterly trend reports.[i]

CS Inspection Quarterly Trend Reports. VHA requires quarterly trend reports summarizing any identified discrepancies, problematic trends, and potential areas for improvement to be provided to either the Facility Director or Consolidated Mail Outpatient Pharmacy Director. During our previous CAP review, we found that the Facility Director did not receive quarterly trend reports. During this review, we found that the Facility Director had not received quarterly trend reports since December 3, 2013.

Follow-Up on Pressure Ulcer Prevention and Management

As a follow-up to recommendations from our previous CAP review, we reassessed facility compliance with patient/caregiver pressure ulcer education.[j]

Patient/Caregiver Pressure Ulcer Education. VHA requires that patients and/or designated family members, surrogates, or authorized decision makers receive educational materials about the prevention of pressure ulcers. During our previous CAP review, we found that the EHRs of patients at risk for or with pressure ulcers did not consistently contain evidence of patient/caregiver pressure ulcer education. During this review, facility managers informed us that acute care employees had not consistently provided pressure ulcer education, and they could not provide documentation that patients at risk for pressure ulcers and/or their caregivers received pressure ulcer education.

Follow-Up on Nurse Staffing

As a follow-up to a recommendation from our previous CAP review, we assessed facility compliance with monitoring the nurse staffing methodology implemented in August 2013.[k]

Nurse Staffing Methodology. VHA requires facility managers to complete annual reassessments of nursing staffing methodologies to assess their effectiveness. During our previous CAP review, we found that the facility had not convened expert panels until August 2013 and recommended that nursing managers monitor the newly implemented staffing methodology. During this review, we found no documented evidence that nursing managers were monitoring the nurse staffing methodology.

Recommendations

24. We recommended that the Controlled Substances Coordinator provide the Facility Director with controlled substances inspection quarterly trend reports.

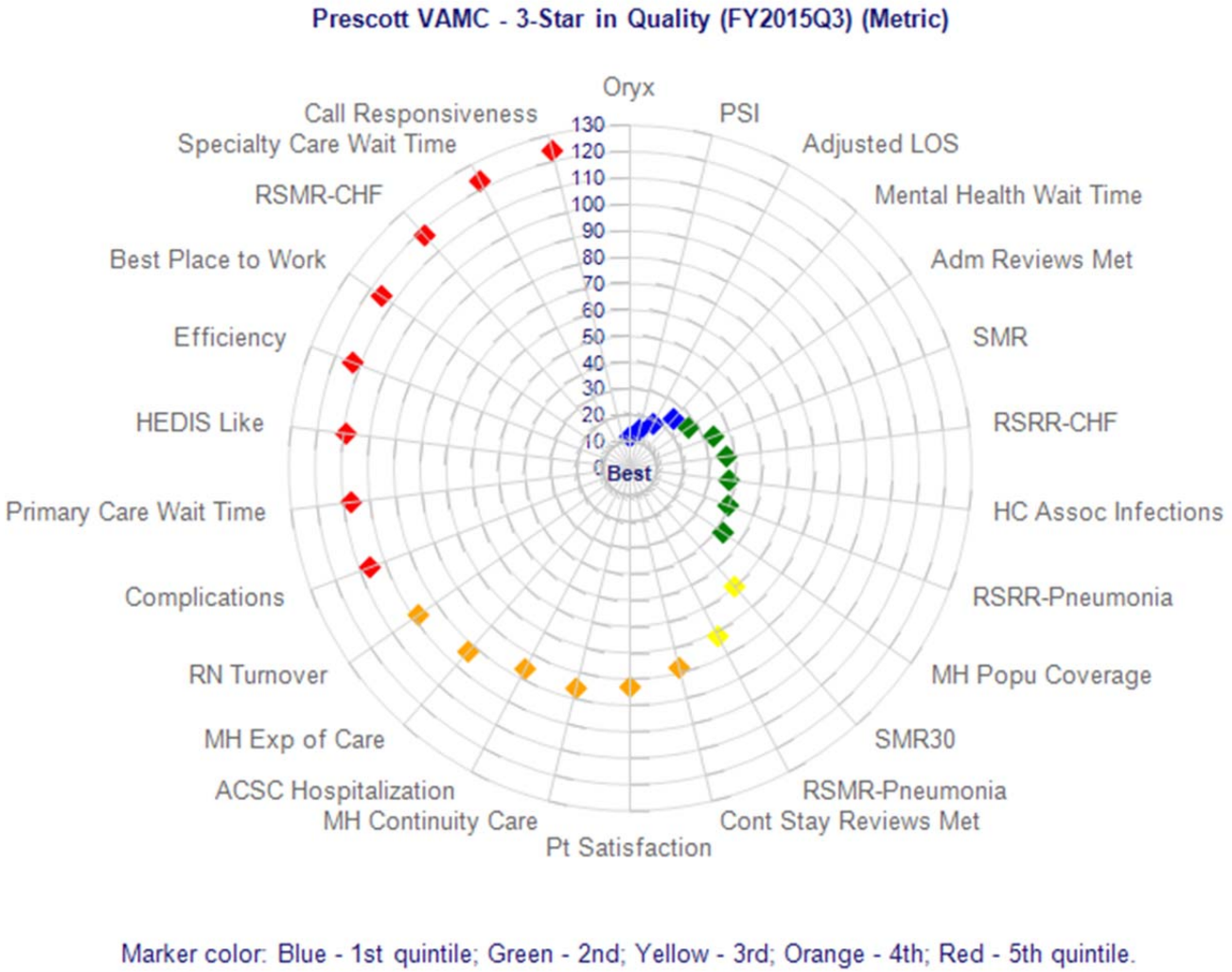
25. We recommended that acute care employees provide pressure ulcer education to patients at risk for or with pressure ulcers and/or their caregivers and document the education and that facility managers monitor compliance.

26. We recommended that nursing managers monitor the staffing methodology implemented in August 2013.

Facility Profile (Prescott/649) FY 2016 through December 2015	
Type of Organization	Secondary
Complexity Level	3-Low complexity
Affiliated/Non-Affiliated	Affiliated
Total Medical Care Budget in Millions	$35
Number of:	
• **Unique Patients**	13,881
• **Outpatient Visits**	49,478
• **Unique Employees**[1]	894
Type and Number of Operating Beds:	
• **Hospital**	21
• **Community Living Center**	85
• **MH**	120
Average Daily Census:	
• **Hospital**	8
• **Community Living Center**	45
• **MH**	40
Number of Community Based Outpatient Clinics	5
Location(s)/Station Number(s)	Kingsman/649GA Flagstaff/649GB Lake Havasu City/649GC Anthem/649GD Cottonwood/649GE
Veterans Integrated Service Network Number	18

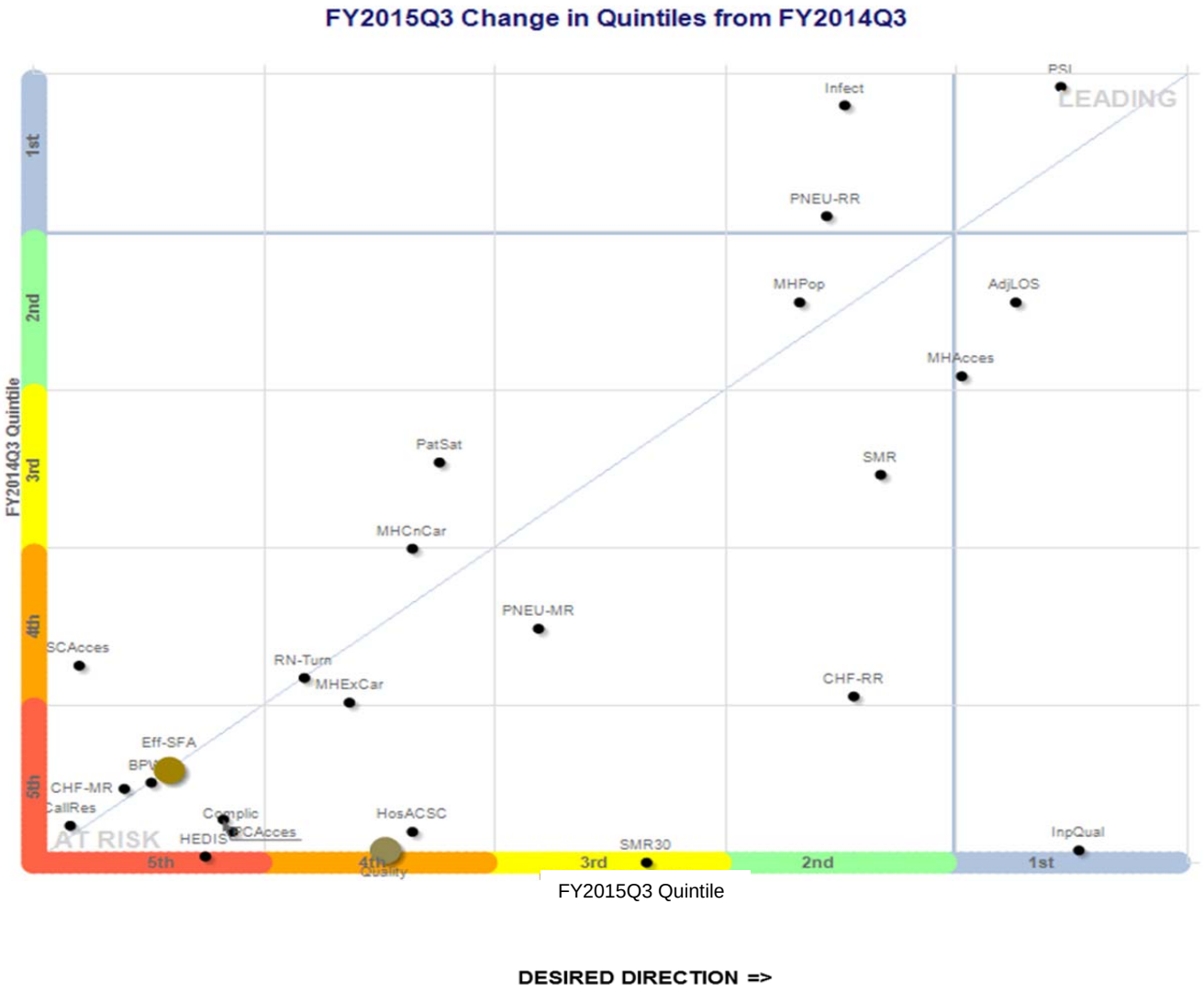
[1] Unique employees involved in direct medical care (cost center 8200).

Strategic Analytics for Improvement and Learning (SAIL)[2]



[2] Metric definitions follow the graphs.

Scatter Chart



DESIRED DIRECTION =>

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

Veterans Integrated Service Network Director Comments

Department of Veterans Affairs

Memorandum

Date: March 7, 2016

From: Director, VA Desert Pacific Healthcare Network (10N22)

Subject: **CAP Review of the Northern Arizona VA Health Care System, Prescott, AZ**

To: Director, Chicago Office of Healthcare Inspections (54CH)

Director, Management Review Service (VHA 10E1D MRS OIG CAP CBOC)

1. Please find the Northern Arizona VA Health Care System response to the Office of Inspector General Health Inspection conducted the week of November 16, 2015, and December 29–30, 2015, report entitled, Combined Assessment Review of the Northern Arizona VA Health Care System, Prescott, Arizona.

2. If you have any questions or concerns, please contact Terri Elsholz, VISN 22 Deputy Quality Management Officer, at 480-397-2782.

(original signed by Jimmie Bates for:)
Marie L. Weldon, FACHE

Acting Facility Director Comments

Department of Veterans Affairs

Memorandum

Date: March 1, 2016

From: Acting Director, Northern Arizona VA Health Care System (649/00)

Subject: **CAP Review of the Northern Arizona VA Health Care System, Prescott, AZ**

To: Director, VA Desert Pacific Healthcare Network (10N22)

1. Please find the Northern Arizona VA Health Care System response to the Office of Inspector General Health Inspection conducted the week of November 16, 2015, and December 29–30, 2015, report entitled, Combined Assessment Review of the Northern Arizona VA Health Care System, Prescott, Arizona.

2. If you have any questions or concerns, please contact James T. Johnson, MD, MSEd, Acting Chief of Staff and Quality Programs Service Line Manager, at 928-445-4860, ext 6010.

(original signed by:)
M. Keith Piatt, MD, FACP, MHA

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 semi-annually and that facility managers monitor compliance.

Concur

Target date for completion: October 30, 2016

Facility response: The Lead Credentialer will provide a monthly list to the Service Line Managers of the Ongoing Professional Practice Evaluations (OPPEs) due. Clinical Pertinence reviews will be initiated by the Clinical Service Lines for all OPPEs due for that rating period. The Service Line Managers will review the aggregated data and sign the completed OPPEs prior to the close of the rating period. Copies of the OPPEs will be sent electronically to the Lead Credentialer to be included in the provider's Professional Practice Folder. The Professional Practice Folder will be taken to the Medical Staff Professional Standards Board for Review. Electronic communication describing this process will be sent to the clinical Service Line Managers. OPPEs will be tracked monthly through the Medical Executive Board. For any delinquent OPPE, education will be provided with deadlines having been reviewed, signed and returned to Credentialing within the completion dates. A target compliance rate of 90% has been established.

Recommendation 2. We recommended that facility managers ensure patient care areas and furnishings and equipment in patient care areas are clean and monitor compliance.

Concur

Target date for completion: September 30, 2016

Facility response: Environmental Management Supervisors and work leaders will monitor cleanliness of patient care areas and furnishings by conducting daily inspection follow ups after areas have been cleaned. The inspection follow ups will be documented as acceptable or marked when remedial work is required. Statistics will be retained and analyzed. The data will be compiled by the Environmental Management Service (EMS) Line Manager and reported to the Environment of Care (EOC) committee on a monthly basis. The EMS Service Line Manager will provide training to EMS staff on the Environmental Program Service Patient Centered Care Improvement Guide and work practices will be modeled on best practices identified.

Recommendation 3. We recommended that facility managers initiate actions to repair damaged furnishings and equipment in patient care areas or remove them from service.

Concur

Target date for completion: September 30, 2016

Facility response: At the next scheduled manager meeting, the FMS [Facilities Management Service] Service Line Manager will inform managers to inspect patient care areas daily and as necessary, place work orders for damaged furnishings and equipment. EMS Staff will be instructed to notify supervisors when damaged furnishings or equipment are identified. EMS Supervisors will then initiate the appropriate work orders. Both the maintenance department and the biomedical equipment department will collect work order data and present to the EOC Board on deficient furnishings and equipment along with timelines for repair. This information will be tracked monthly via the EOC Board to identify trends and areas for additional corrective action.

Recommendation 4. We recommended that the facility consistently monitor temperature in the inpatient pharmacy compounding buffer areas and that facility managers monitor compliance.

Concur

Target date for completion: October 30, 2016

Facility response: Thermometers have been placed in both the chemo and non-hazardous intravenous (IV) buffer areas. The inpatient pharmacists will monitor the temperature in both locations twice daily (in the morning and evening) documenting on a temperature log. The Pharmacy Service Line Manager will monitor the daily completion of the log. A target compliance rate of 90% has been established.

Recommendation 5. We recommended that facility managers ensure employees perform and document monthly cleaning of storage shelving in all compounding areas and monitor compliance.

Concur

Target date for completion: October 30, 2016

Facility response: A dedicated Certified IV Pharmacy Technician will perform scheduled monthly cleaning of all IV compounding areas. The Certified Pharmacy Technician will document monthly cleaning on a cleaning log. The Pharmacy Service Line Manager will monitor completion of the cleaning log monthly. A target compliance rate of 90% has been established.

Recommendation 6. We recommended that facility managers ensure all hoods are certified at least every 6 months and monitor compliance.

Concur

Target date for completion: February 28, 2017

Facility response: In order to ensure all hoods are certified at least every 6 months, the non-hazardous IV hood which failed inspection, has been decommissioned. The Facilities Service Line Manager is responsible to schedule hood certification which is routinely scheduled for February and August. The missed February 2016 inspection will be scheduled for March 2016 and then the hood inspection will resume as regularly scheduled inspections in August 2016 and February 2017. Once the decommissioned hood is replaced, the Facilities Service Line Manager will ensure continuing biannual certification. The Facilities Service Line Manager will ensure a copy of the hood inspection report is given to the Pharmacy Service Line Manager and reported at the next scheduled EOC/Safety Board meeting.

Recommendation 7. We recommended that facility managers develop a temporary bed location policy.

Concur

Target date for completion: June 30, 2016

Facility response: The Associate Chief of Nursing Operations, Risk Manager and Continued Readiness Coordinator will revise the Bed Management Health Care System Memorandum (HCSM) to address temporary bed location as required by VHA Directive 1009.

Recommendation 8. We recommended that the Facility Director appoint a Bed Flow Coordinator with a clinical background.

Concur

Target date for completion: June 30, 2016

Facility response: The Facility Director will appoint a Bed Flow Coordinator with a clinical background. The Associate Chief of Nursing Operations, Risk Manager and Continued Readiness Coordinator will revise the Bed Management HCSM to include the Bed Flow Coordinator.

Recommendation 9. We recommended that physicians consistently document discharge progress notes or instructions that include all required elements and that facility managers monitor compliance.

Concur

Target date for completion: June 30, 2016

Facility response: The Utilization Management Coordinator will provide education to hospitalists on completing discharge progress notes or instructions that include all required elements required by VHA Handbook 1907.01, Health Information Management and Health Records. The Continued Readiness Coordinator will conduct monthly audits on discharged patients to ensure progress notes or instructions include all required elements. Quarterly reports will be reviewed by the Medical Records Committee. A target compliance rate of 90% has been established.

Recommendation 10. We recommended that the facility develop a computed tomography policy and procedures that include all required components.

Concur

Target date for completion: October 30, 2016

Facility response: The Service Line Manager, the Interim Radiology Manager and the Radiation Safety Officer will collaborate to develop a computed tomography policy and procedures that include all required components addressed in the VHA Directive.

Recommendation 11. We recommended that the Radiation Safety Officer ensure all computed tomography technologists have documented annual radiation safety training.

Concur

Target date for completion: October 30, 2016

Facility response: In order to ensure that the computed tomography technologists have documented annual radiation safety training, the Radiation Safety Officer or designee will monitor the annual training for CT techs is documented in the CT tech's competency file.

Recommendation 12. We recommended that employees consistently correctly post patients' advance directives status and that facility managers monitor compliance.

Concur

Target date for completion: October 30, 2016

Facility response: The Social Work (SW) Chief will provide Advance Directive Discussion and Documentation Training to acute care SWs. SW Service will conduct

monthly compliance audits to monitor the use of the Advance Directive Discussion progress note to document the patient's correct advance directive status. SW will submit quarterly reports to the Medical Records Committee. A compliance target rate of 90% has been established.

Recommendation 13. We recommended that employees ask inpatients whether they would like to discuss creating, changing, and/or revoking advance directives and that facility managers monitor compliance.

Concur

Target date for completion: October 30, 2016

Facility response: SW Chief will provide Advance Directive Discussion and Documentation Training to Acute Care social workers. SW Service will conduct monthly compliance audits to monitor the use of the Advance Directive Discussion progress note and submit a quarterly report to the Medical Records Committee. A compliance target rate of 90% has been established.

Recommendation 14. We recommended that facility managers ensure new clinical employees complete suicide risk management training within the required timeframe and monitor compliance.

Concur

Target date for completion: October 30, 2016

Facility response: The Suicide Prevention Training for new non-clinical employees and the Suicide Risk Management Training for new clinical employees will be added to the New Employee Orientation curriculum, which occurs in the first week of employment. All new employees will be required to complete this training in order to successfully complete New Employee Orientation. This will be added to the New Employee Orientation by the end of fiscal year 2016. Until the new curriculum is implemented, the Suicide Prevention Coordinator will send an email to all facility supervisors and managers directing them to ensure their staff have completed these training sessions immediately, or within the required timeframe (3 months of start date). The Suicide Prevention Coordinator will request a list from the Education Department on delinquent employees at the end of FY 2016 Quarters 3 and 4. Staff and supervisors will be appropriately notified of any delinquencies. Compliance audits will be submitted to the Risk Manager and quarterly reports will be presented at the Quality Performance Board (QPB). A compliance target rate of 90% has been established.

Recommendation 15. We recommended that the Suicide Prevention Coordinator provide at least five community outreach activities every month and maintain documentation of these activities and that facility managers monitor compliance.

Concur

Target date for completion: October 30, 2016

Facility response: The Suicide Prevention Coordinator (SPC) will provide documentation of outreach activities to the Mental Health Program Manager (MHPM) at the end of quarter 3 (June 30, 2016) and quarter 4 (September 30, 2016) and report outcomes to the QPB. A compliance target rate of 100% has been established.

Recommendation 16. We recommended that clinicians consistently assess patients for suicide risk prior to placing a high risk for suicide flag and that facility managers monitor compliance.

Concur

Target date for completion: October 30, 2016

Facility response: Mental Health Behavioral Services (MHBS) clinicians will be trained by the SPC and MHPM through electronic mail and in-service sessions. Training and emails will address specific guidance in VHA Directive 2008-036, Section 2008.07, for placing High Risk Flags. Clinicians will follow the VHA Directive to ensure best practices for increased identification and protection of high risk Veteran patients. The SPC and the MHPM will perform monthly audits of electronic health records with high risk suicide flags. Results of the audits will be reported by the Risk Manager to the QPB quarterly. A compliance target rate of 100% has been established.

Recommendation 17. We recommended that clinicians not place flags in the electronic health records of moderate- and low-risk patients and that facility managers monitor compliance.

Concur

Target date for completion: October 30, 2016

Facility response: Clinicians will be trained by the SPC and MHPM through electronic mail and in-service sessions on placing high risk flags according to VHA Directive 2008-036. The SPC and the MHPM will perform monthly audits of electronic health records with high risk suicide flags to ensure appropriate use of the high risk flag. Results of the audits will be reported by the Risk Manager to the QPB quarterly. A compliance target rate of 90% has been established.

Recommendation 18. We recommended that clinicians include the contact numbers of family or friends for support in Suicide Prevention Safety Plans and that facility managers monitor compliance.

Concur

Target date for completion: October 30, 2016

Facility response: MHBS staff will be trained through electronic communication and in-service sessions to ensure proper completion of Suicide Prevention Safety Plans. In both formats, clinicians will be directed to identify the SPC as an additional signer on the Safety Plans. The SPC and Program Manager will perform quarterly audits of all Suicide Prevention Safety Plans to ensure proper documentation of contact numbers of family or friends. Results of the audits will be reported by the Risk Manager to the QPB quarterly. A compliance target rate of 90% has been established.

Recommendation 19. We recommended that clinicians ensure patients and/or caregivers receive a copy of the Suicide Prevention Safety Plan and that facility managers monitor compliance.

Concur

Target date for completion: October 30, 2016

Facility response: The SPC and the Suicide Program Manager will work with the Clinical Applications Coordinator to revise the Suicide Prevention Safety Plan Template to include a statement at the bottom of the form stating, "A copy of this Safety Plan has been given to the Veteran." The SPC and the Suicide Program Manager will provide training for the MHBS clinicians via electronic communication and Service Line staff meeting to ensure a copy of the Suicide Prevention Safety Plan is given to the Veteran. The SPC and the Suicide Program Manager will perform quarterly audits of all Suicide Prevention Safety Plans and query 20% of the Veterans to confirm receipt of the Safety Plan. Results of the audits will be reported by the Risk Manager to the QPB quarterly. For patients reporting not having received a copy, an alert will be issued to the provider to ensure the patient receives a copy of the Safety Plan. A compliance target rate of 90% has been established.

Recommendation 20. We recommended that treatment teams review patients' high-risk flags at least every 90 days and that facility managers monitor compliance.

Concur

Target date for completion: October 30, 2016

Facility response: The SPC updated the facility database for tracking Flagged High Risk patients to include a category that identifies when the 90-day review is due and a check box to indicate the 90-day review was completed. The SPC will pull 90-day review data from VISTA to identify any past-due reviews as a cross-check. The SPC

and the MHPM will monitor all 90-day reviews quarterly to ensure compliance. Results of the audits will be reported by the Risk Manager to the QPB quarterly. A compliance target rate of 90% has been established.

Recommendation 21. We recommended that facility managers establish a mammography services policy.

Concur

Target date for completion: June 30, 2016

Facility response: In order to ensure facility managers establish a mammography services policy, the Women Veterans Program Manager will collaborate with the Assistant Service Line Manager for Primary Care to develop a mammography services policy in accordance with VHA Handbook 1105.03 Mammography Program Procedures and Standards and VHA Handbook 1330.01 Health Care Services for Women Veterans.

Recommendation 22. We recommended that clinicians link mammogram results to the radiology order in the electronic health record and that facility managers monitor compliance.

Concur

Target date for completion: October 30, 2016

Facility response: A multi-disciplinary workgroup will be formed to create a process for linking external mammogram results to the radiology order. Through this workgroup, the ownership of the process will be determined to monitor compliance of the process. Once the process is established, monthly audits will begin. Quarterly reports will be reviewed by the Medical Records Committee. A target compliance rate of 90% has been established.

Recommendation 23. We recommended that facility managers ensure ordering clinicians receive signed written mammography reports within 30 days of the procedure date and monitor compliance.

Concur

Target date for completion: October 30, 2016

Facility response: The Community Managed Care Service Line Manager or designee will run a weekly report for open active mammogram consults. The open consults will be reviewed to see if a signed written mammography report was received by the ordering clinician. If no signed written mammography report has been received, the Community Managed Care Service Line Manager will contact Tri-West to obtain results. The Community Managed Care Service Line Manager will monitor the weekly report and submit a monthly report to the Compliance Committee on the timely receipt of

signed written mammography reports for the ordering clinician. A compliance target rate of 90% has been established.

Recommendation 24. We recommended that Controlled Substances Coordinator provide the Facility Director with controlled substances inspection quarterly trend reports.

Concur

Target date for completion: October 30, 2016

Facility response: The Controlled Substances Coordinator will submit a quarterly trend report to the Facility Director for FY16 Q2 in April 2016 and for FY16 Q3 in July 2016 and continue to submit quarterly trend reports in accordance with the Controlled Substance Report Submission Schedule.

Recommendation 25. We recommended that acute care employees provide pressure ulcer education to patients at risk for or with pressure ulcers and/or their caregivers and document the education and that facility managers monitor compliance.

Concur

Target date for completion: October 30, 2016

Facility response: Acute care RNs will be provided education on providing pressure ulcer education to patients at risk for or with pressure ulcers and/or their caregivers. The Acute Care Nurse Manager, the Assistant Acute Care Nurse Manager and the Facility Wound Care Nurse are responsible for providing this education. The Wound Care Nurse will contact the Get Well Network and add a module on Pressure Ulcer Education which will be assigned at the time of the patient's admission. The Wound Care Nurse developed an educational brochure for patients in addition to/or in lieu of watching the TV Pressure Ulcer education. The Acute Care Nurse Manager and the Assistant Acute Care Nurse Manager will conduct monthly audits of patients at risk for/or with pressure ulcers for documentation of education via the Get Well Network and/or the Pressure Ulcer Brochure. Quarterly reports will be reviewed by the Medical Records Committee. A target compliance rate of 90% has been established.

Recommendation 26. We recommended that nursing managers monitor the staffing methodology implemented in August 2013.

Concur

Target date for completion: October 30, 2016

Facility response: The facility leadership will define a policy for linking staffing levels and staff mix to patient outcomes consistent with the VHA Staff Methodology for VHA Personnel Directive 2010-034. Each nurse manager and the Unit-Based Expert Panel will formulate staffing recommendations to develop a targeted Nursing Hours Per

Patient Day (NHPPD) for the unit. Nurse Managers will submit the completed unit-based expert panel package to the facility expert panel for review. The expert panel will review the information and forward recommendations to the Nurse Executive. The Nurse Executive will review the staffing plan for nursing personnel and FTE [full-time equivalent] requirements and utilize the Resource Committee process for final approval of the staffing plans. The facility Director will endorse the final staffing plan. On a daily basis the nurse managers will monitor the staffing plan implemented and note any variance from the targeted NHPPD. At a minimum, the staffing plan will be evaluated on an annual basis, or more frequently if needed.

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	Alicia Castillo-Flores, MBA, MPH, Team Leader Debra Boyd-Seale, RN, PhD Sheila Cooley, GNP, MSN Wachita Haywood, RN Tanya Smith-Jeffries, LCSW, MBA Richard Cady, Resident Agent in Charge, Office of Investigations
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This report is available at **www.va.gov/oig**.

Endnotes

[a] The 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] The 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] The 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] The 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] The 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 references used for this topic included:
- VHA Handbook 1330.01, *Health Care Services for Women Veterans*, May 21, 2010.
- VHA Handbook 1105.03, *Mammography Program Procedures and Standards*, April 28, 2011.

[i] The reference used for this topic was:
- VHA Handbook 1108.02, *Inspection of Controlled Substances*, March 31, 2010.

[j] The reference used for this topic was:
- VHA Handbook 1108.02, *Prevention of Pressure Ulcers*, July 1, 2011.

[k] The reference used for this topic was:
- VHA Directive 2010-034, *Staffing Methodology for VHA Nursing Personnel*, July 19, 2010.