Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 15-04706-104

Combined Assessment Program Review of VA Butler Healthcare Butler, Pennsylvania

January 28, 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

CAP	Combined Assessment Program
CS	controlled substance
EHR	electronic health record
EOC	environment of care
facility	VA Butler Healthcare
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
RRTP	residential rehabilitation treatment program
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Table of Contents

Executive Summary

Review Purpose: The purpose of the review was to evaluate selected health care facility operations, focusing on patient care quality and the environment of care, and to provide crime awareness briefings. We conducted the review the week of November 30, 2015.

Review Results: The review covered eight activities. We made no recommendations in the following three activities:

- Medication Management – Controlled Substances Inspection Program
- Continuity of Care
- Management of Workplace Violence

The facility's reported accomplishment was initiating acupuncture care.

Recommendations: We made recommendations in the following five activities:

Quality, Safety, and Value: Consistently review Ongoing Professional Practice Evaluation data semiannually.

Environment of Care: Ensure all dental clinic employees complete bloodborne pathogens training annually.

Mammography Services: Ensure the Women Veterans Program Manager has sufficient allocated administrative time for oversight duties and does not provide direct patient care more than 1/8 of her time (5 hours per week).

Suicide Prevention Program: Develop and document Suicide Prevention Safety Plans. Include in Suicide Prevention Safety Plans contact numbers of family or friends for support. Review patients' high-risk flags at least every 90 days.

Mental Health Residential Rehabilitation Treatment Program: Ensure the Domiciliary Care for Homeless Veterans and Substance Abuse Domiciliary has written agreements in place acknowledging resident responsibility for medication security.

Comments

The Interim Veterans Integrated Service Network Director and Facility Director agreed with the Combined Assessment Program review findings and recommendations and provided acceptable improvement plans. (See Appendixes C and D, pages 24–28, for

the full text of the Directors' comments.) We consider recommendations 2 and 3 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 eight activities:

- QSV
- EOC
- Medication Management – CS Inspection Program
- Continuity of Care
- Mammography Services
- Suicide Prevention Program
- Management of Workplace Violence
- MH RRTP

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 2015 and FY 2016 through December 3, 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 VA Butler Healthcare, Butler, Pennsylvania,* Report No. 13-01672-260, July 25, 2013).

During this review, we presented crime awareness briefings for 91 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 179 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

Initiation of Acupuncture Care

In June 2015, the facility opened a full-time acupuncture clinic with two licensed acupuncturists providing services. The acupuncture clinic (along with an established chiropractic clinic) provides alternative pain management. Acupuncture is used mainly to relieve discomfort associated with a variety of diseases and conditions such as chronic pain; pain of the low back, neck, arm, wrist, hip, or leg; headaches, including migraines; and neuropathy.

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.	• Nineteen profiles did not contain evidence that clinical managers reviewed Ongoing Professional Practice Evaluation data semiannually.	**1.** We recommended that facility clinical managers consistently review Ongoing Professional Practice Evaluation data semiannually 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.		
NA	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 two community living center inpatient units. We also inspected the dental, primary care, physical medicine and rehabilitation, women's health, podiatry, and ophthalmology clinics. Additionally, we reviewed relevant documents and eight 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
	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.	• Two of eight dental clinic employees did not have documentation of bloodborne pathogens training during the past 12 months.	**2.** 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 – CS Inspection Program

The purpose of this review was to determine whether the facility complied with requirements related to CS security and inspections.[c]

We reviewed relevant documents and conversed with key employees. We also reviewed the training files of all CS Coordinators and nine CS inspectors and inspection documentation from three CS areas, the pharmacy, and the emergency drug cache. 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
	Facility policy was consistent with VHA requirements.		
	VA police conducted annual physical security surveys of the pharmacy/pharmacies, and the facility corrected any identified deficiencies.		
	The facility had documented instructions for inspecting automated dispensing machines that included all required elements, and CS inspectors followed the instructions.		
	The CS Coordinator provided monthly CS inspection findings summaries and quarterly trend reports to the Facility Director.		
	The CS Coordinator position description or functional statement included CS oversight duties, and the CS Coordinator completed required certification and was free from conflicts of interest.		
	The facility Director appointed CS inspectors in writing, and inspectors were limited to 3-year terms, completed required certification and training, and were free from conflicts of interest.		

NM	Areas Reviewed (continued)	Findings	Recommendations
	CS inspectors inspected non-pharmacy areas with CS in accordance with VHA requirements, and inspections included all required elements.		
	CS inspectors conducted pharmacy CS inspections in accordance with VHA requirements, and inspections included all required elements.		
	The facility complied with any additional elements required by VHA or local policy.		

Continuity of Care

The purpose of this review was to evaluate whether clinical information from patients' community hospitalizations at VA expense was scanned and available to facility providers and whether providers documented acknowledgement of it.[d]

We reviewed relevant documents and the EHRs of 29 patients who had been hospitalized at VA expense in the local community September 1, 2014, through August 8, 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
	Clinical information was consistently available to the primary care team for the clinic visit subsequent to the non-VA hospitalization.		
	Members of the patients' primary care teams documented that they were aware of the patients' non-VA hospitalization.		
	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.[e]

We reviewed relevant documents and the EHRs of 18 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 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
	The facility had a policy addressing mammography services that included required elements.		
	If the facility outsourced mammograms, it defined requirements for turnaround time.		
	Clinicians linked mammogram results to the radiology order in the EHR.		
	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.		
	Clinicians communicated incomplete or “probably benign” results to the patient within 14 days from availability of the results and documented this in the EHR.		

NM	Areas Reviewed (continued)	Findings	Recommendations
	The facility ensured ordering clinicians received signed written mammography reports within 30 days of the procedure date.		
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.		
X	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 Women Veterans Program Manager was involved in direct patient care more than 1/8 of her time (5 hours per week).	**3.** We recommended that the facility ensure the Women Veterans Program Manager has sufficient allocated administrative time for oversight duties and does not provide direct patient care more than 1/8 of her time (5 hours per week).
	The facility had established effective mammography oversight processes.		
	The facility complied with 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.[f]

We reviewed relevant documents and conversed with key employees. Additionally, we reviewed the EHRs of 20 patients assessed to be at risk for suicide during the period July 1, 2014–June 30, 2015, plus any 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.		
NA	Clinicians assessed patients for suicide risk at the time of admission.		

NM	Areas Reviewed (continued)	Findings	Recommendations
	Clinicians appropriately placed Patient Record Flags: • High-risk patients received Patient Record Flags. • Moderate- and low-risk patients did not receive Patient Record Flags.		
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	• Two of 19 applicable EHRs did not contain safety plans. • Five of 17 safety plans lacked documentation of contact numbers of family or friends for support.	**4.** We recommend that clinicians develop and document Suicide Prevention Safety Plans and that facility managers monitor compliance. **5.** We recommended that clinicians include contact numbers of family or friends for support 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.		
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.	• Six of the 20 EHRs did not contain evidence that the treatment team reviewed patients' high-risk flags at least every 90 days.	**6.** 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.		

Management of Workplace Violence

The purpose of this review was to determine the extent to which the facility complied with selected requirements in the management of workplace violence.[g]

We reviewed relevant documents, three Reports of Contact from disruptive patient/employee/other (visitor) incidents that occurred during the 18-month period June 2014–November 2015, and 10 training records of employees who worked in areas at low or moderate risk for violence. Additionally, we conversed with key employees. The table below shows the areas reviewed for this topic. Any items that did not apply to this facility are marked NA. The facility generally met requirements. We made no recommendations.

NM	Areas Reviewed	Findings	Recommendations
	The facility had a policy, procedure, or guideline on preventing and managing workplace violence.		
	The facility conducted an annual Workplace Behavioral Risk Assessment.		
	The facility had implemented: • A process to address employee threat • A Disruptive Behavior Committee/Board • A disruptive behavior reporting and tracking system		
	The facility used and tested appropriate physical security precautions and equipment in accordance with the local risk assessment.		
	The facility had an employee security training plan that either used the mandated prevention and management of disruptive behavior training or an alternative that addressed the issues of awareness, preparedness, precautions, and police assistance. • Employees received the required training.		

NM	Areas Reviewed (continued)	Findings	Recommendations
	The facility managed selected incidents appropriately according to its policy.		
	The facility complied with any additional elements required by VHA or local policy.		

MH RRTP

The purpose of this review was to determine whether the facility's Domiciliary Care for Homeless Veterans and Substance Abuse Domiciliary complied with selected EOC requirements.[h]

We reviewed relevant documents, inspected the Domiciliary Care for Homeless Veterans and Substance Abuse Domiciliary, and conversed with key employees. The table below shows the areas reviewed for this topic. The area marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

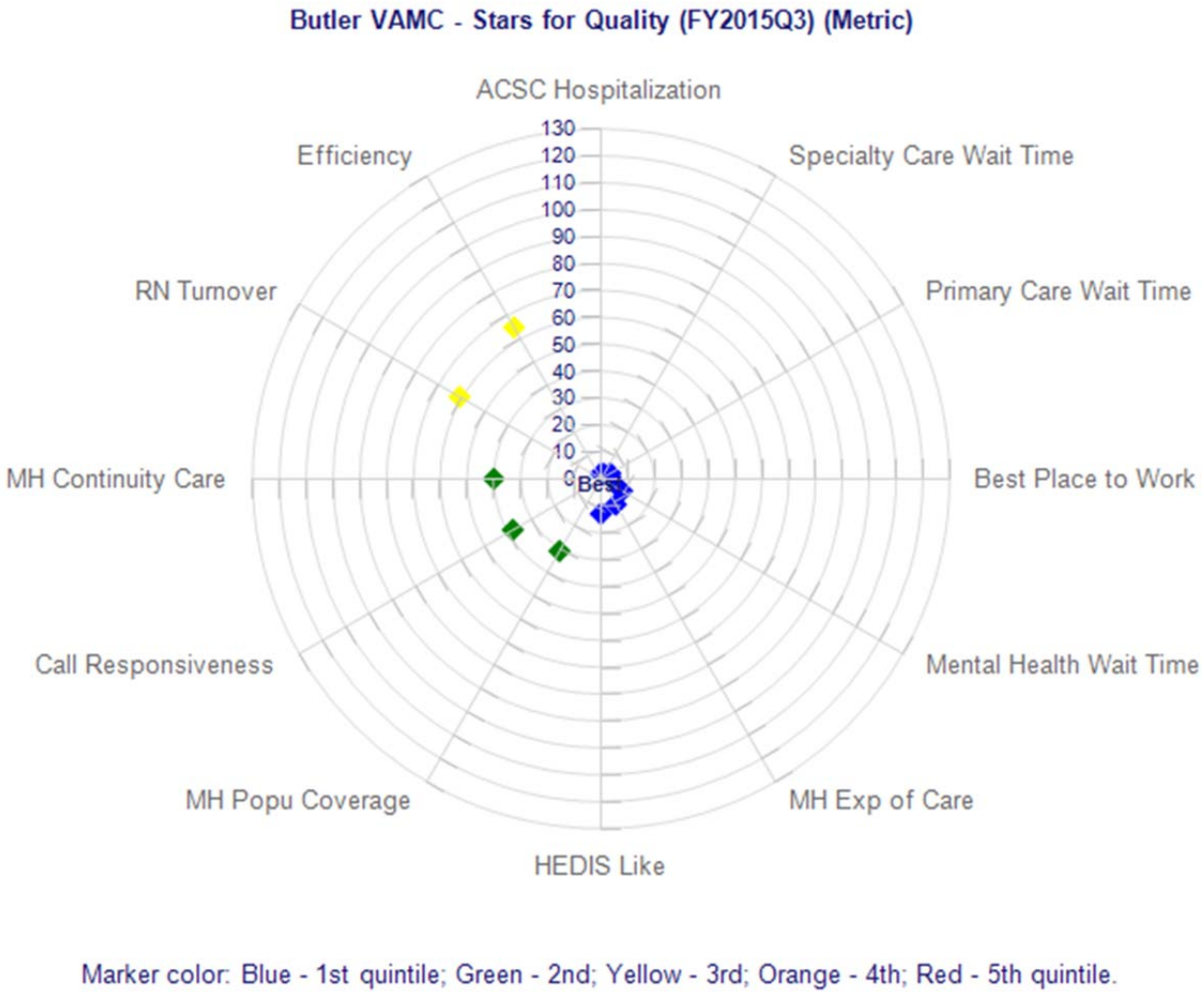
NM	Areas Reviewed	Findings	Recommendations
	The residential environment was clean and in good repair.		
	Appropriate fire extinguishers were available near grease producing cooking devices.		
	There were policies/procedures that addressed safe medication management and contraband detection.		
	MH RRTP employees conducted and documented monthly MH RRTP self-inspections that included all required elements, submitted work orders for items needing repair, and ensured correction of any identified deficiencies.		
	MH RRTP employees conducted and documented contraband inspections, rounds of all public spaces, daily bed checks, and resident room inspections for unsecured medications.		
X	The MH RRTP had written agreements in place acknowledging resident responsibility for medication security.	• The domiciliary did not have two of 10 written agreements in place.	**7.** We recommended that domiciliary managers ensure the Domiciliary Care for Homeless Veterans and Substance Abuse Domiciliary has written agreements in place acknowledging resident responsibility for medication security.

NM	Areas Reviewed (continued)	Findings	Recommendations
	MH RRTP main point(s) of entry had keyless entry and closed circuit television monitoring, and all other doors were locked to the outside and alarmed.		
	The MH RRTP had closed circuit television monitors with recording capability in public areas but not in treatment areas or private spaces and signage alerting veterans and visitors of recording.		
	There was a process for responding to behavioral health and medical emergencies, and MH RRTP employees could articulate the process.		
NA	In mixed gender MH RRTP units, women veterans' rooms had keyless entry or door locks, and bathrooms had door locks.		
	Residents secured medications in their rooms.		
	The facility complied with any additional elements required by VHA or local policy.		

Facility Profile (Butler/529) FY 2016 through December 2015	
Type of Organization	Secondary
Complexity Level	3-Low complexity
Affiliated/Non-Affiliated	Affiliated
Total Medical Care Budget in Millions	$17.2
Number of:	
• **Unique Patients**	10,920
• **Outpatient Visits**	34,632
• **Unique Employees**[1]	422
Type and Number of Operating Beds:	
• **Hospital**	NA
• **Community Living Center**	97
• **MH**	56
Average Daily Census:	
• **Hospital**	NA
• **Community Living Center**	48
• **MH**	42
Number of Community Based Outpatient Clinics	5
Location(s)/Station Number(s)	Hermitage/529GA New Castle/529GB Ford City/529GC Foxburg/529GD Cranberry Township/529GF
VISN Number	4

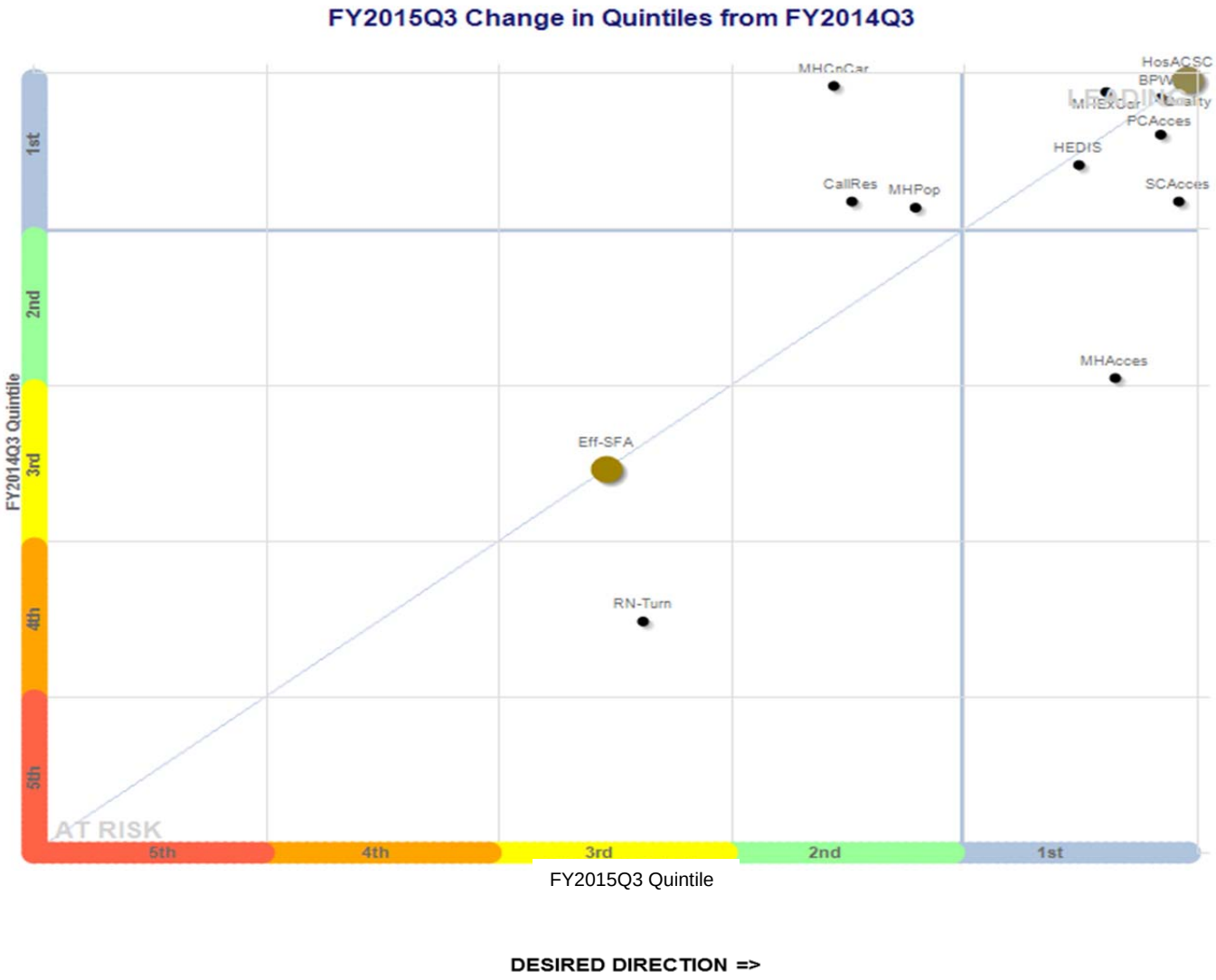
[1] Unique employees involved in direct medical care (cost center 8200).

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



[2] Metric definitions follow the graphs.

Scatter Chart



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

Interim VISN Director Comments

Department of Veterans Affairs

Memorandum

Date: January 5, 2016

From: Interim Director, VA Healthcare – VISN 4 (10N4)

Subject: **CAP Review of VA Butler Healthcare, Butler, PA**

To: Director, Baltimore Office of Healthcare Inspections (54BA)

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

1. I have reviewed the responses provided by VA Butler Healthcare and I am submitting to your office as requested. I concur with all responses.

2. If you have any questions or require additional information, please contact Moira Hughes, VISN 4 Quality Management Officer at 412-822-3294.

William H. Mills

Attachment

Facility Director Comments

Department of Veterans Affairs

Memorandum

Date: January 4, 2016

From: Director, VA Butler Healthcare (529/00)

Subject: **CAP Review of VA Butler Healthcare, Butler, PA**

To: Interim Director, VA Healthcare – VISN 4 (10N4)

The findings from the CAP Review of VA Butler Healthcare, conducted during the week of November 30, 2015, have been reviewed.

Attached is the facility's response addressing all recommendations that are in progress and those that have been completed.

David P. Cord

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 consistently review Ongoing Professional Practice Evaluation data semiannually and that facility managers monitor compliance.

Concur

Target date for completion: April 10, 2016

Facility response: A review form was developed on December 4, 2015, and added to the Ongoing Professional Practice Evaluation Tool. This form will be utilized by the Clinical Service Chief at each six month review to assure the results are reviewed with each Licensed Independent Practitioner. The Service Chief/designee will monitor that the form is signed and dated, indicating that the findings have been reviewed. This monitor will continue until 90% compliance is achieved for three consecutive months.

Recommendation 2. We recommended that dental clinic managers ensure all dental clinic employees complete bloodborne pathogens training annually and monitor compliance.

Concur

Target date for completion: December 4, 2015

Facility response: All dental clinic employees have completed Blood Borne Pathogen Training as evidenced by the verification. This training has been added to the New Employee Orientation as well as to the Mandatory Annual Training requirement for contract staff. All staff are automatically alerted on the annual due date. The Associate Chief of Staff/Ambulatory Care is responsible for assuring all mandatory training is completed annually.

Recommendation 3. We recommended that the facility ensure the Women Veterans Program Manager has sufficient allocated administrative time for oversight duties and does not provide direct patient care more than 1/8 of her time (5 hours per week).

Concur

Target date for completion: January 4, 2016

Facility response: The Women Veterans Program Manager is scheduled in the primary care clinic for four hours per week effective January 4, 2016.

Recommendation 4. We recommend that clinicians develop and document Suicide Prevention Safety Plans and that facility managers monitor compliance.

Concur

Target date for completion: April 10, 2016

Facility response: The safety plan completion process was reviewed with applicable staff members during a face to face meeting. The Suicide Prevention Coordinator will monitor completion of the safety plans until 90% compliance is achieved for three consecutive months.

Recommendation 5. We recommended that clinicians include contact numbers of family or friends for support in Suicide Prevention Safety Plans and that facility managers monitor compliance.

Concur

Target date for completion: April 10, 2016

Facility response: The Suicide Prevention Coordinator has been added as an additional signer (in the Computerized Patient Record System) to all safety plans to assure that the plan is completed with contact numbers of family/friends. The Suicide Prevention Coordinator will monitor completion of the safety plans until 90% compliance is achieved for three consecutive months.

Recommendation 6. 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: April 10, 2016

Facility response: The safety plan completion process was reviewed with applicable staff members during a face to face meeting. The Suicide Prevention Coordinator/designee will monitor the records of all high risk patient record flags every 90 days to assure that the Mental Health Treatment Coordinator and Suicide Risk Reduction Team review each case and recommend continuation or inactivation of the flag(s). The final recommendation will be documented in the patient record.

Recommendation 7. We recommended that domiciliary managers ensure the Domiciliary Care for Homeless Veterans and Substance Abuse Domiciliary has written agreements in place acknowledging resident responsibility for medication security.

Concur

Target date for completion: April 10, 2016

Facility response: All Domiciliary staff has been educated on the completion of the medication security agreement. The Nurse Manager will monitor that all domiciliary patients have a signed medication policy reviewed by the nurse upon admission. This monitor will continue until 90% compliance is achieved for three consecutive months.

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	Jennifer Christensen, DPM, Team Leader Terri Julian, PhD Francis Keslof, EMT, MHA Alison Loughran, JD, RN Margie Chapin, RT (R, MR, CT), JD Melanie Oppat, MEd, LDN Timothy Barry, Resident Agent In Charge, Office of Investigations
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U.S. House of Representatives: Mike Doyle, Mike Kelly, Keith Rothfus, Glenn W. Thompson

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 1108.01, *Controlled Substances (Pharmacy Stock)*, November 16, 2010.
- VHA Handbook 1108.02, *Inspection of Controlled Substances*, March 31, 2010.
- VHA Handbook 1108.05, *Outpatient Pharmacy Services*, May 30, 2006.
- VA Handbook 0730, *Security and Law Enforcement*, August 11, 2000.
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[d] The references used for this topic were:
- VHA Handbook 1907.01, *Health Information Management and Health Records*, March 19, 2015.
- Various requirements of the Joint Commission.

[e] References used for this topic included:
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- VHA Handbook 1105.03, *Mammography Program Procedures and Standards*, April 28, 2011.

[f] References used for this topic included:
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- *VA Suicide Prevention Coordinator Manual*, August 2014.
- Various requirements of The Joint Commission.

[g] References used for this topic were:
- VHA Directive 2009-008 (also listed as 2010-008), *Standards for Mental Health Coverage in Emergency Departments and Urgent Care Clinics in VHA Facilities*, February 22, 2010.
- VHA Directive 2012-026, *Sexual Assaults and Other Defined Public Safety Incidents in Veterans Health Administration (VHA) Facilities*, September 27, 2012.
- Under Secretary for Health, "Violent Behavior Prevention Program," Information Letter 10-97-006, February 3, 1997.
- Various requirements of the Occupational Safety and Health Administration.

[h] References used for this topic were:
- VHA Handbook 1162.02, *Mental Health Residential Rehabilitation Treatment Program (MH RRTP)*, December 22, 2010.
- VHA Handbook 1330.01, *Health Care Services for Women Veterans*, May 21, 2010.
- Requirements of the VHA Center for Engineering and Occupational Safety and Health and the National Fire Protection Association.