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Clinical Assessment Program Review of the Lexington VA Medical Center Lexington, Kentucky

July 19, 2017

Washington, DC 20420

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Glossary

CAP	Clinical Assessment Program
CBOC	community based outpatient clinic
CNH	community nursing home
EHR	electronic health record
EOC	environment of care
facility	Lexington VA Medical Center
FY	fiscal year
MH	mental health
NA	not applicable
NM	not met
OIG	Office of Inspector General
PC	primary care
POCT	point-of-care testing
QSV	quality, safety, and value
RME	reusable medical equipment
RRTP	residential rehabilitation treatment program
SPS	Sterile Processing Service
VHA	Veterans Health Administration

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Executive Summary

Purpose and Objectives: The review provided an evaluation of the quality of care delivered in the inpatient and outpatient settings of the Lexington VA Medical Center. We reviewed clinical and administrative processes that affect patient care outcomes—Quality, Safety, and Value; Environment of Care; Medication Management; Coordination of Care; Diagnostic Care; Moderate Sedation; Community Nursing Home Oversight; Management of Disruptive/Violent Behavior; and Mental Health Residential Rehabilitation Treatment Program. We also followed up on recommendations from the previous Combined Assessment Program and Community Based Outpatient Clinic and Primary Care Clinic reviews and provided crime awareness briefings.

Results: We conducted the review during the week of February 6, 2017, and identified certain system weaknesses in utilization management; general safety and security; environmental cleanliness; reusable medical equipment reprocessing and competency assessment; bloodborne pathogens training; anticoagulation policy, procedures, and competency assessment; transfer documentation; moderate sedation practices and training; community nursing home program oversight; disruptive and violent behavior management and training; Mental Health Residential Rehabilitation Treatment Program privacy; and mental health unit panic alarm testing.

Review Impact: As a result of the findings, we could not gain reasonable assurance that:

1. Utilization management decisions are made with physician advisors' input.
2. The facility has effective processes for reusable medical equipment reprocessing and ensures a clean and safe Sterile Processing Service environment.
3. Cooper Division managers maintain clean ventilation grills and monitor after-hours visitors.
4. The hemodialysis unit manager maintains an effective process to ensure employees receive required bloodborne pathogens training.
5. Anticoagulation management program policies include all requirements, employees use quality assurance data to improve care for anticoagulation patients, and clinicians have documented competency to manage anticoagulation patients.
6. Transfer notes contain required elements.
7. Moderate sedation clinicians safely discharge outpatients from the recovery area and have current training for the provision of moderate sedation care.
8. Facility leaders consistently monitor the community nursing home program and assure the safe care of patients in those homes.

9. The facility effectively manages disruptive/violent behavior incidents and ensures employees receive training to reduce and prevent disruptive behaviors.
10. The facility maintains privacy in the Mental Health Residential Rehabilitation Treatment Program environment.
11. The facility has a safe mental health unit environment.

Recommendations: We made recommendations in the following eight review areas.

Quality, Safety, and Value – Ensure that:
- Physician Utilization Management Advisors consistently document their decisions in the National Utilization Management Integration database.

Environment of Care – Ensure that:
- The Infection Control Committee documents analysis of surveillance data related to follow-up activities for the hemodialysis unit and Sterile Processing Service areas.
- Facility managers at the Cooper Division implement the use of a visitors log during non-business hours.
- Ceiling ventilation grills in patient care areas at the Cooper Division are clean.
- Quality control testing is performed on endoscopes that exceed a 12-day hang time.
- Sterile Processing Service employees receive training and competencies for the types of reusable medical equipment they reprocess.
- Wall and ceiling holes and damaged areas in Sterile Processing Service areas are repaired.
- Employees entering Sterile Processing Service areas wear the required personal protective equipment.
- Current standard operating procedures for reusable medical equipment are located in the area where reprocessing occurs.
- The distance of items stored below a sprinkler deflector complies with Joint Commission standards.
- All hemodialysis unit employees receive annual bloodborne pathogens training.

Medication Management: Anticoagulation Therapy – Ensure that:
- Facility policy for anticoagulation management includes required baseline laboratory tests.
- Quality assurance data for the anticoagulation management program is reviewed biannually.
- Competency assessment for employees actively involved in the anticoagulant program includes nutrient interactions and drug to drug interactions associated with anticoagulation therapy.

Coordination of Care: Inter-Facility Transfers – Ensure that:
- Transfer notes written by acceptable designees document staff/attending physician approval and contain a staff/attending physician countersignature.

Moderate Sedation – Ensure that:

- Clinical employees discharge outpatients from the recovery area according to provider orders or criteria approved by moderate sedation clinical leaders.
- Clinical employees who perform or assist with moderate sedation procedures have current training for the provision of moderate sedation care and that training is documented.

Community Nursing Home Oversight – Ensure that:

- The Community Nursing Home Oversight Committee includes representation by all required disciplines.
- The community nursing home program is integrated into the facility's quality improvement program.
- Registered nurses conduct and document cyclical clinical visits with the frequency required by Veterans Health Administration policy for community nursing home oversight.

Management of Disruptive/Violent Behavior – Ensure that:

- Clinicians inform patients about the Patient Record Flags and their right to request to amend/appeal flag placement.
- All employees receive Level 1 Prevention and Management of Disruptive Behavior training and additional training as required for their assigned risk area within 90 days of hire and that training is documented in employee training records.

Mental Health Residential Rehabilitation Treatment Program – Ensure that:

- Substance Abuse and Post-Traumatic Stress Disorder Residential Rehabilitation Treatment Program monthly self-inspections include assessment of privacy.

We also made the following repeat recommendation from the previous Combined Assessment Program review.

Panic Alarm Testing – Ensure that:

- Locked mental health unit panic alarm testing includes VA Police response time.

Comments

The Acting Veterans Integrated Service Network Director and Facility Director agreed with the Clinical Assessment Program review findings and recommendations and provided acceptable improvement plans. (See Appendixes E and F, pages 42–52, for the full text of the Directors' comments.) We will follow up on the planned actions until they are completed.

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Purpose and Objectives

Purpose

This CAP review provided an evaluation of the quality of care delivered in the inpatient and outpatient settings of the facility.

Objectives

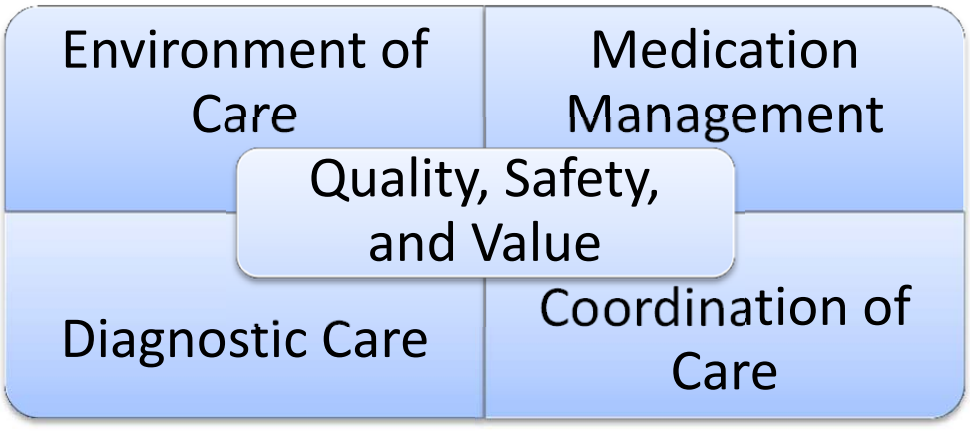
CAP reviews are one element of OIG's efforts to ensure that our Nation's veterans receive high quality VA health care services. The reviews include cyclical evaluations of key clinical and administrative processes that affect patient care outcomes. Areas of focus include QSV, EOC, Medication Management, Coordination of Care, and Diagnostic Care.

OIG also evaluates processes that are high risk and problem-prone—Moderate Sedation, CNH Oversight, Management of Disruptive/Violent Behavior, and MH RRTP—and follows up on recommendations from the previous Combined Assessment Program and CBOC and PC Clinic reviews. Additionally, OIG provides crime awareness briefings to increase employee understanding of the potential for program fraud and the requirement to refer suspected criminal activity to OIG.

Background

We evaluate key aspects of clinical care delivery in a variety of primary/specialty care and inpatient/outpatient settings. These aspects include QSV, EOC, Medication Management, Coordination of Care, and Diagnostic Care (see Figure 1 below).

Figure 1. Comprehensive Coverage of Continuum of Care



Source: VA OIG

Quality, Safety, and Value

According to the Institute of Medicine (now the National Academy of Medicine), there are six important components of a health care system that provides high quality care to individuals. The system:

1. Is safe (free from accidental injury) for all patients, in all processes, all the time.
2. Provides care that is effective (care that, wherever possible, is based on the use of systematically obtained evidence to make determinations regarding whether a preventive service, diagnostic test, therapy, or no intervention would produce the best outcome).
3. Is patient-centered. This concept includes respect for patients' values and preferences; coordination and integration of care; information, communication, and education; physical comfort; and involvement of family and friends.
4. Delivers care in a timely manner (without long waits that are wasteful and often anxiety-provoking).
5. Is efficient (uses resources to obtain the best value for the money spent).
6. Is equitable (bases care on an individual's needs and not on personal characteristics—such as gender, race, or insurance status—that are unrelated to the patient's condition or to the reason for seeking care).[1]

One of VA's strategies is to deliver high quality, veteran-centered care that compares favorably to the best of the private sector in measured outcomes, value, efficiency, and patient experience.[2]

Environment of Care

All facilities face environmental risks, including those associated with safety and security, fire, hazardous materials and waste, medical equipment, and utility systems. The EOC is made up of three basic elements: (1) the building or space; (2) equipment used to support patient care; and (3) people who enter the environment.[3]

The physical environment shapes every patient experience and all health care delivery, including those episodes of care that result in patient harm. Three patient safety areas are markedly influenced by the environment—health care-associated infections, medication safety, and falls. Because health care-associated infections are transmitted through air, water, and contact with contaminated surfaces, the physical environment plays a key role in preventing the spread of infections in health care settings. Medication safety is markedly influenced by physical environmental conditions, including light levels and workspace organization. Environmental factors, such as the

[1] Teleki SS, Damberg, CL, Reville RT. *Quality of Health Care: What Is It, Why Is It Important, and How Can It Be Improved in California's Workers Compensation Programs?* Santa Monica: RAND Corporation; May 2003 Quality and Workers' Compensation Working Draft.
[2] Department of Veterans Affairs, VHA. *Blueprint for Excellence*. September 2014.
[3] The Joint Commission. *Comprehensive Accreditation Manual for Hospitals: E-dition*®: Joint Commission Resources; July 2016: Environment of Care (EC).

placement of doorways, flooring type, and the location of furniture, can contribute to patient falls and associated injuries.[4]

Medication Management

Comprehensive medication management is defined as the standard of care that ensures clinicians individually assess each patient's medications to determine that each is appropriate for the patient, effective for the medical condition, safe given the comorbidities and other medications prescribed, and able to be taken by the patient as intended. Medications are involved in 80 percent of all treatments and impact every aspect of a patient's life. Drug therapy problems occur every day. The Institute of Medicine (now the National Academy of Medicine) noted that while medications account for only 10 percent of total health care costs, their ability to control disease and impact overall costs, morbidity, and productivity—when appropriately used—is enormous. The components of the medication management process include procuring, storing, securing, prescribing or ordering, transcribing, preparing, dispensing, and administering.[5,6]

Coordination of Care

Coordination of care is the process of coordinating care, treatment, or services provided by a facility, including referring individuals to appropriate community resources to meet ongoing identified needs, implementing the plan of care, and avoiding unnecessary duplication of services. Coordination of care is recognized as a major challenge in the safe delivery of care. The rise of chronic illness means that a patient's care, treatment, and services likely will involve an array of providers in a variety of health care settings, including the patient's home.[7]

In a 2001 report entitled "Crossing the Quality Chasm: A New Health System for the 21st Century," the Institute of Medicine (now the National Academy of Medicine) noted that, "Because of the special vulnerability that accompanies illness or injury, coordination of care takes on special importance. Many patients depend on those who provide care to coordinate services—whether tests, consultations, or procedures—to ensure that accurate and timely information reaches those who need it at the appropriate time." Health care providers and organizations need to work together to coordinate their efforts to provide safe, quality care.[8]

[4] Joseph A, Malone EB. *The Physical Environment: An Often Unconsidered Patient Safety Tool*. Agency for Healthcare Research and Quality. Patient Safety Network; October 2012.
[5] Patient-Centered Primary Care Collaborative. *The Patient-Centered Medical Home: Integrating Comprehensive Medication Management to Optimize Patient Outcomes, Resource Guide*. 2nd ed; June 2012.
[6] The Joint Commission. *Comprehensive Accreditation Manual for Hospitals: E-dition*®: Joint Commission Resources; July 2016: Medication Management (MM).
[7] The Joint Commission. *Comprehensive Accreditation Manual for Hospitals: E-dition*®: Joint Commission Resources; July 2016: Provision of Care, Treatment, and Services (PC).
[8] Institute of Medicine. *Crossing the Quality Chasm: A New Health System for the 21st Century*. The National Academies Press; March 2001.

Diagnostic Care

The diagnostic process is a complex, patient-centered, collaborative activity that involves information gathering and clinical reasoning with the goal of determining a patient's health problem. Diagnostic testing may occur in successive rounds of information gathering, integration, and interpretation, with each round refining the working diagnosis. PC clinicians order laboratory tests in slightly less than one third of patient visits, and direct-to-patient testing is becoming increasingly prevalent.[9]

Medical imaging also plays a critical role in establishing the diagnoses for many conditions. The advancement of imaging technologies has improved the ability of clinicians to detect, diagnose, and treat conditions while also allowing patients to avoid more invasive procedures. In many cases, medical imaging can identify a condition before it is clinically apparent; for example, an imaging study indicating the presence of coronary artery blockage can identify coronary artery disease even in the absence of symptoms. Performed appropriately, diagnostic care facilitates the provision of timely, cost-effective, and high quality medical care.[10]

High-Risk and Problem-Prone Health Care Processes

Health care leaders must give priority to high-volume, high-risk, or problem-prone processes for performance improvement activities.[11] "Specifically, they are responsible for identifying high-risk areas that could cause harm to patients, visitors, and employees; implementing programs to avert risks; and managing a robust reporting process for adverse events that do occur. But of all of their responsibilities, one of the most important is focusing on improving patient safety."[12]

Moderate sedation is a drug-induced depression of consciousness during which patients can still respond purposefully to verbal comments.[13] Properly credentialed providers and trained clinical employees must provide safe care while sedating patients for invasive procedures. Additionally, facility leaders must monitor moderate sedation adverse events, report and trend the use of reversal agents, and systematically aggregate and analyze the data to enhance patient safety and employee performance.[14]

[9] Committee on Diagnostic Error in Health Care. Balogh EP, Miller BT, Ball JR, eds. *Improving Diagnosis in Health Care*. Washington, DC: The National Academies Press; 2015: Chap. 2.
[10] Department of Veterans Affairs. Patient Care Services. Diagnostic Services. http://www.patientcare.va.gov/diagnosticservices.asp. Accessed September 21, 2016.
[11] The Joint Commission. *Comprehensive Accreditation Manual for Hospitals: E-dition*®: Joint Commission Resources; July 2016: Leadership (LD) Accreditation Requirements, LD.04.04.01, EP2.
[12] Bickmore, AM. Streamlining the Risk Management Process in Healthcare to Improve Workflow and Increase Patient Safety, *HealthCatalyst*, https://www.healthcatalyst.com/streamlining-risk-management-process-healthcare.
[13] American Society of Anesthesiologists (ASA), Practice Guidelines for Sedation and Analgesia by Non-Anesthesiologists, 2002. Anesthesiology 2002; 96:1004-17.
[14] VHA Directive 1073, *Moderate Sedation by Non-Anesthesiology Providers*, December 30, 2014.

As of October 2016, VHA has contracts with more than 1,800 CNHs where more than 9,500 veteran patients reside.[15] These CNHs may be either in close proximity to a VA facility or located hundreds of miles away. VHA requires local oversight of CNHs, which includes monitoring and follow-up services for patients who choose to reside in nursing homes in the community. This oversight involves annual reviews and monthly patient visits unless otherwise specified.[16]

According to the U.S. Bureau of Labor Statistics, health care workers are nearly five times more likely to be victims of nonfatal assaults or violent acts in their work places than average workers in all industries combined. Many of these assaults and violent acts are perpetrated by patients.[17] Management of disruptive/violent behavior involves the development of policies, programs, and initiatives for reducing and preventing disruptive behaviors and other defined acts that threaten public safety.[18] VHA released a directive that addresses the management of all individuals in VHA facilities whose behavior could jeopardize the health or safety of others, undermine a culture of safety in VHA, or otherwise interfere with the delivery of health care at a facility. Unfortunately, staff training deadlines have been postponed several times.[19]

MH RRTPs provide 24-hour residential rehabilitative and clinical care in a therapeutic setting to eligible veterans who have multiple and severe medical conditions, mental illnesses, addictions, or psychosocial deficits. They provide the least intensive level of VA inpatient care and differ from acute inpatient and nursing home beds as veterans in MH RRTPs are generally capable of self-care. MH RRTPs address rehabilitation, recovery, health maintenance, improved quality of life, and community integration in addition to specifically treating medical conditions, mental illnesses, and addictive disorders. Facility leaders must provide a safe, well-maintained, and appropriately-furnished residential environment that supports and enhances recovery efforts.[20]

[15] VA Corporate Data Warehouse. Accessed October 31, 2016.
[16] VHA Handbook 1143.2, *VHA Community Nursing Home Oversight Procedures,* June 4, 2004.
[17] U.S. Bureau of Labor Statistics. Janocha JA, Smith RT. *Workplace Safety and Health in the Health Care and Social Assistance Industry, 2003–07*. http://www.bls.gov/opub/mlr/cwc/workplace-safety-and-health-in-the-health-care-and-social-assistance-industry-2003-07.pdf. August 30, 2010. Accessed October 28, 2016.
[18] VHA Directive 2012-026, *Sexual Assaults and Other Defined Public Safety Incidents in Veterans Health Administration (VHA) Facilities,* September 27, 2012.
[19] VHA Chief Learning Officer. "VHA Approval to Temporarily Suspend Talent Management System (TMS) Required Training Assignments." Memorandum. March 21, 2016.
[20] VHA Handbook 1162.02, *Mental Health Residential Rehabilitation Treatment Program (MH RRTP),* December 22, 2010.

Scope

To evaluate for compliance with requirements related to patient care quality, clinical functions, and the EOC, we physically inspected selected areas, discussed processes and validated findings with managers and employees, and reviewed clinical and administrative records. The review covered the following five aspects of clinical care.

- Quality, Safety, and Value
- Environment of Care
- Medication Management: Anticoagulation Therapy
- Coordination of Care: Inter-Facility Transfers
- Diagnostic Care: Point-of-Care Testing

We also evaluated four additional review areas because of inherent risks and potential vulnerabilities.

- Moderate Sedation
- Community Nursing Home Oversight
- Management of Disruptive/Violent Behavior
- Mental Health Residential Rehabilitation Treatment Program

We list the review criteria for each of the review areas in the topic checklists.

The review covered operations for FY 2015, FY 2016, and FY 2017 through February 10, 2017, and inspectors conducted the reviews 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 Combined Assessment Program report (*Combined Assessment Program Review of the Lexington VA Medical Center, Lexington, Kentucky,* Report No. 13-03652-59, February, 3, 2014) and CBOC report (*Community Based Outpatient Clinic and Primary Care Clinic Reviews at Lexington VA Medical Center, Lexington, Kentucky,* Report No. 13-03418-44, January 16, 2014). We made a repeat recommendation for panic alarm testing. (See page 30.)

We presented crime awareness briefings to 295 employees. These briefings covered procedures for reporting suspected criminal activity to 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 360 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 OIG to monitor until the facility implements corrective actions. When issues and concerns outside the scope of this CAP review come to our attention, they can be referred for further review separate from this report.

Reported Accomplishments

Direct Scheduling

In July 2016, the facility implemented a direct scheduling process for routine audiology and optometry exams. This new process enables patients to schedule a routine hearing or eye exam on their own, eliminating the need for a PC visit to obtain a specialty consult and increasing access to hearing and eye services. As a result of the direct scheduling process, consults from PC to audiology decreased by 84 percent, and consults from PC to optometry decreased by 89 percent.

Registered Nurse Turnover Initiatives

In FY 2015, the facility's registered nurse turnover performance measure was in the 5th quintile (bottom 20 percent of facilities) of the Strategic Analytics for Improvement and Learning (SAIL) report, meaning the registered nurse turnover rate was high. The facility implemented the following actions and initiatives to decrease registered nurse turnover (improve registered nurse retention):

- Started a local chapter of Nurses Organization of Veterans Affairs to influence legislators on veterans' health care issues
- Increased funding and awards for the National Nursing Education Initiative
- Started a VA National Education for Employees Program to provide health care related scholarships for employees
- Gave recruitment bonuses for intensive care unit and operating room nurses
- Implemented standardized orientation tools and progress meetings between nurse managers and new employees
- Implemented a shared governance model, nursing quarterly forums, and meetings with nursing leadership
- Improved employee and manager engagement processes through regular rounds, staff meetings, and huddles

As a result, there is improved employee engagement, communication, and transparency. As of the 4th quarter of FY 2016, the registered nurse turnover rate had decreased, and the performance measure was in the 1st quintile (top 20 percent of facilities) of the Strategic Analytics for Improvement and Learning (SAIL) report.

Results and Recommendations

Quality, Safety, and Value

The purpose of this review was to determine whether the facility complied with selected QSV program requirements.[a] VHA requires that its facilities operate a QSV program to monitor patient care quality and performance improvement activities. Many QSV activities are required by VHA directives, accreditation standards, and Federal regulations. Public Law 100-322 mandates VA's OIG to oversee VHA quality improvement programs at every level. This review focuses on the following program areas.

- Senior-level committee or group with responsibility for QSV/performance improvement
- Protected peer review
- Credentialing and privileging
- Utilization management
- Patient safety

We interviewed senior managers and key QSV employees, and we evaluated meeting minutes, 25 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.

Checklist 1. QSV Areas Reviewed, Findings, and Recommendations

NM	Areas Reviewed	Findings	Recommendations
	There was a senior-level committee responsible for key QSV functions that met at least quarterly and was co-chaired by the Facility Director. • The committee routinely reviewed aggregate data.		

NM	Areas Reviewed (continued)	Findings	Recommendations
	Credentialing and privileging processes met selected requirements: • Facility policy/by-laws specified 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.		
	Protected peer reviews met selected requirements: • Peer reviewers documented their use of important aspects of care in their review, such as appropriate and timely ordering of diagnostic tests, timely treatment, and appropriate documentation. • When the Peer Review Committee recommended individual improvement actions, clinical managers implemented the actions.		
X	Utilization management met selected requirements: • The facility completed at least 75 percent of all required inpatient reviews. • Physician Utilization Management Advisors documented their decisions in the National Utilization Management Integration database. • An interdisciplinary group reviewed utilization management data.	• For 40 of the 179 cases (22 percent) referred to Physician Utilization Management Advisors from November 23, 2016 to January 23, 2017, there was no evidence that advisors documented their decisions in the National Utilization Management Integration database. This resulted in less data for the facility to use to set benchmarks; identify trends, actions, and opportunities to improve efficiency; and monitor outcomes.	**1.** We recommended that Physician Utilization Management Advisors consistently document their decisions in the National Utilization Management Integration database and that facility managers monitor compliance.

NM	Areas Reviewed (continued)	Findings	Recommendations
	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 2016, the Patient Safety Manager submitted an annual patient safety report to facility leaders.		
	Overall, if QSV reviews identified significant issues, the facility took actions and evaluated them for effectiveness.		
	Overall, senior managers actively participated in QSV activities.		

Environment of Care

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 SPS and the hemodialysis unit.[b]

VHA must manage risks in the environment in order to promote a safe, functional, and supportive environment. Further, VHA must establish a systematic infection prevention and control program to reduce the possibility of acquiring and transmitting infections. We selected the hemodialysis unit and SPS as special emphasis areas due to the increased potential for exposure to infectious agents inherent to hemodialysis and procedures using RME. Hemodialysis patients are at higher risk for infections for various reasons, including that hemodialysis requires vascular access for prolonged periods of time and that opportunities exist for transmission of infectious agents when multiple patients receive dialysis concurrently. RME is intended for repeated use on different patients after being reprocessed through cleaning, disinfection, and/or sterilization. Patients undergoing procedures using RME are at higher risk of exposure to infectious agents if RME is not properly reprocessed.

At the Cooper Division, we inspected the medical/surgical (3N), medical/surgical/telemetry (5N), intensive care, hemodialysis, and locked MH units; the Emergency Department; the chemotherapy clinic; and SPS areas. At the Leestown Division, we inspected the hospice unit, community living center (units 1 and 2), and women's clinic. We also inspected the Hazard/Perry County CBOC. Additionally, we reviewed relevant documents and 17 employee training records, and we interviewed key employees and managers. The table below shows the areas reviewed for this topic. The areas marked as NM did not meet applicable requirements and needed improvement.

Checklist 2. EOC Areas Reviewed, Findings, and Recommendations

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 CBOCs.		
	The facility conducted an infection prevention risk assessment.		

NM	Areas Reviewed for General EOC (continued)	Findings	Recommendations
X	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.	Six months of Infection Control Committee meeting minutes reviewed: • Minutes did not consistently reflect analysis of surveillance data related to follow-up on activities for the hemodialysis unit and SPS areas in order to effectively manage the risks of acquiring and transmitting infections.	**2.** We recommended that the Infection Control Committee document analysis of surveillance data related to follow-up activities for the hemodialysis unit and Sterile Processing Service areas.
	The facility had established a procedure for cleaning equipment between patients.		
	The facility conducted required fire drills in buildings designated for health care occupancy and documented drill critiques.		
X	The facility had a policy/procedure/guideline for identification of individuals entering the facility, and units/areas complied with requirements.	Facility policy for identification of individuals entering the facility reviewed: • The Cooper Division did not have a log for recording facility visitors during non-business hours.	**3.** We recommended that facility managers at the Cooper Division implement the use of a visitors log during non-business hours and monitor compliance.
	The facility met general safety requirements.		
X	The facility met environmental cleanliness requirements.	• In three of six patient care areas at the Cooper Division, multiple ceiling ventilation grills were dusty.	**4.** We recommended that facility managers at the Cooper Division ensure ceiling ventilation grills in patient care areas are clean and monitor compliance.
	Areas Reviewed for SPS		
	The facility had a policy for cleaning, disinfecting, and sterilizing RME.		
	The facility's standard operating procedures for selected RME were current and consistent with the manufacturers' instructions for use.		

NM	Areas Reviewed for SPS (continued)	Findings	Recommendations
X	The facility performed quality control testing on selected RME with the frequency required by local policy and took appropriate action on positive results.	• The facility did not perform quality control testing on endoscopes that were not used on patients but exceeded a 12-day hang time.	**5.** We recommended that Sterile Processing Service managers ensure quality control testing is performed on endoscopes that exceed a 12-day hang time and monitor compliance.
X	Selected SPS employees had evidence of the following for selected RME: • Training and competencies at orientation if employed less than or equal to 1 year • Competencies within the past 12 months or with the frequency required by local policy if employed more than 1 year	• For four of five SPS employees, there was no documentation of current competencies for selected RME.	**6.** We recommended that Sterile Processing Service managers ensure Sterile Processing Service employees receive training and competencies for the types of reusable medical equipment they reprocess.
X	The facility met infection prevention requirements in SPS areas.	• In multiple areas, there were holes and damaged areas on walls and ceilings. • We observed SPS employees exiting and re-entering an SPS area without the required shoe covers.	**7.** We recommended that facility managers ensure wall and ceiling holes and damage are repaired. **8.** We recommended that facility managers ensure employees entering Sterile Processing Service areas wear the required personal protective equipment and monitor compliance.
X	Standard operating procedures for selected RME were located in the area where reprocessing occurred.	• Current standard operating procedures for the colonoscope, esophagogastroduodenoscopy, and retrograde cholangiopancreatography endoscopes were not located in the area where reprocessing occurred.	**9.** We recommended that facility managers ensure current standard operating procedures for reusable medical equipment are located in the area where reprocessing occurs.
	SPS employees checked eyewash stations in SPS areas weekly.		
	SPS employees had access to Safety Data Sheets in areas where they used hazardous chemicals.		

NM	Areas Reviewed for SPS (continued)	Findings	Recommendations
X	The facility complied with Joint Commission requirements for items stored in SPS.	The Joint Commission requires that items stored in SPS be at least 18 inches from a sprinkler head: • Items stored in the SPS prep room were stored less than 18 inches from a sprinkler head.	**10.** We recommended that facility managers ensure the distance of items stored below a sprinkler deflector complies with Joint Commission standards and monitor compliance.
	Areas Reviewed for the Hemodialysis Unit		
	The facility had a policy or procedure for preventive maintenance of hemodialysis machines and performed maintenance at the frequency required by local policy.		
X	Selected hemodialysis unit employees had evidence of blood borne pathogens training within the past 12 months.	• For 2 of 12 hemodialysis unit employees, there was no documentation of bloodborne pathogens training during the past 12 months.	**11.** We recommended that facility managers ensure all hemodialysis unit employees receive annual bloodborne pathogens training and monitor compliance.
	The facility met environmental safety requirements on the hemodialysis unit.		
	The facility met infection prevention requirements on the hemodialysis unit.		
	The facility met medication safety and security requirements on the hemodialysis unit.		
	The facility met privacy requirements on the hemodialysis unit.		

Medication Management: Anticoagulation Therapy

The purpose of this review was to determine whether facility clinicians appropriately managed and provided education to patients with new orders for anticoagulant medication.[c] During FY 2016, more than 482,000 veterans received an anticoagulant. Anticoagulants (commonly called blood thinners) are a class of drugs that work to prevent the coagulation or clotting of blood. For this review, we evaluated warfarin (Coumadin®) and direct-acting oral anticoagulants. Clinicians use anticoagulants for both the treatment and prevention of cardiac disease, cerebrovascular accident (stroke), and thromboembolism[21] in both the inpatient and outpatient setting. Although these medications offer substantial benefits, their use or misuse carries a significant potential for patient harm. A dose less than the required amount for therapeutic effect can increase the risk of thromboembolic complications while a dose administered at levels greater than required for treatment can increase the risk of bleeding complications. The Joint Commission's National Patient Safety Goal 3.05.01 focuses on improving anticoagulation safety to reduce patient harm and states, "…anticoagulation medications are more likely than others to cause harm due to complex dosing, insufficient monitoring, and inconsistent patient compliance."

We reviewed relevant documents and the competency assessment records of 10 employees actively involved in the anticoagulant program, and we interviewed key employees. Additionally, we reviewed the EHRs of 35 randomly selected patients who were prescribed new anticoagulant medications from July 1, 2015 through June 30, 2016. The table below shows the areas reviewed for this topic. The areas marked as NM did not meet applicable requirements and needed improvement.

Checklist 3. Medication Management: Anticoagulation Therapy Areas Reviewed, Findings, and Recommendations

NM	Areas Reviewed	Findings	Recommendations
X	The facility had policies and processes for anticoagulation management that included required content.	• Facility policy did not include required baseline laboratory tests.	**12.** We recommended that the facility revise the anticoagulation management policy to include required baseline laboratory tests.
	The facility used algorithms, protocols or standardized care processes for the: • Initiation and maintenance of warfarin • Management of anticoagulants before, during, and after procedures • Use of weight-based, unfractionated heparin		

[21] Thromboembolism is the obstruction of a blood vessel by a blood clot that has become dislodged from another site in the circulation.

NM	Areas Reviewed (continued)	Findings	Recommendations
	The facility provided patients with a direct telephone number for anticoagulation-related calls during normal business hours and defined a process for patient anticoagulation-related calls outside normal business hours.		
	The facility designated a physician as the anticoagulation program champion.		
	The facility defined ways to minimize the risk of incorrect tablet strength dosing errors.		
X	The facility routinely reviewed quality assurance data for the anticoagulation management program at the facility's required frequency at an appropriate committee.	• The facility did not review quality assurance data for the anticoagulation management program biannually.	**13.** We recommended that the facility review quality assurance data for the anticoagulation management program biannually and that facility managers monitor compliance.
	For inpatients with newly prescribed anticoagulant medications, clinicians provided transition follow-up and education specific to the new anticoagulant.		
	Clinicians obtained required laboratory tests: • Prior to initiating anticoagulant medications • During anticoagulation treatment at the frequency required by local policy		
	When laboratory values did not meet selected criteria, clinicians documented a justification/rationale for prescribing the anticoagulant.		
X	The facility required competency assessments for employees actively involved in the anticoagulant program, and clinical managers completed competency assessments that included required content at the frequency required by local policy.	• For all 10 anticoagulant program employees, competency assessments did not include: o Nutrient interactions associated with anticoagulation therapy o Drug to drug interactions associated with anticoagulation therapy	**14.** We recommended that facility managers include nutrient interactions and drug to drug interactions associated with anticoagulation therapy in competency assessments for employees actively involved in the anticoagulant program and monitor compliance.

Coordination of Care: Inter-Facility Transfers

The purpose of this review was to evaluate selected aspects of the facility's patient transfer process, specifically transfers out of the facility.[d] Inter-facility transfers are frequently necessary to provide patients with access to specific providers or services. The movement of an acutely ill person from one institution to another exposes the patient to risks, while in some cases, failing to transfer a patient may be equally risky. VHA has the responsibility to ensure that transfers into and out of its medical facilities are carried out appropriately, under circumstances that provide maximum safety for patients, and comply with applicable standards.

We reviewed relevant documents and interviewed key employees. Additionally, we reviewed the EHRs of 48 randomly selected patients who were transferred acutely out of facility inpatient beds or the Emergency Department/urgent care center to another VHA facility or non-VA facility from July 1, 2015 through June 30, 2016. The table below shows the areas reviewed for this topic. The area marked as NM did not meet applicable requirements and needed improvement.

Checklist 4. Coordination of Care: Inter-Facility Transfers Areas Reviewed, Findings, and Recommendations

NM	Areas Reviewed	Findings	Recommendations
	The facility had a policy that addressed patient transfers and included required content.		
	The facility collected and reported data about transfers out of the facility.		
	Transferring providers completed VA Form 10-2649A and/or transfer/progress notes prior to or within a few hours after the transfer that included the following elements: • Date of transfer • Documentation of patient or surrogate informed consent • Medical and/or behavioral stability • Identification of transferring and receiving provider or designee • Details of the reason for transfer or proposed level of care needed		

NM	Areas Reviewed (continued)	Findings	Recommendations
X	When staff/attending physicians did not write transfer notes, acceptable designees: • Obtained and documented staff/attending physician approval • Obtained staff/attending physician countersignature on the transfer note	• In 7 of the 48 EHRs (15 percent), transfer notes written by acceptable designees did not document staff/attending physician approval, and 4 of the 7 notes did not contain a staff/attending physician countersignature.	**15.** We recommended that facility managers ensure transfer notes written by acceptable designees document staff/attending physician approval and contain a staff/attending physician countersignature and monitor compliance.
	When the facility transferred patients out, sending nurses documented transfer assessments/notes.		
	In emergent transfers, providers documented: • Patient stability for transfer • Provision of all medical care within the facility's capacity		
	Communication with the accepting facility or documentation sent included: • Available history • Observations, signs, symptoms, and preliminary diagnoses • Results of diagnostic studies and tests		

Diagnostic Care: Point-of-Care Testing

The purpose of this review was to evaluate the facility's glucometer POCT program compliance with applicable laboratory regulatory standards and quality testing practices as required by VHA, the College of American Pathologists, and The Joint Commission.[e] The majority of laboratory testing is performed in the main laboratory. However, with newer technologies, testing has emerged from the laboratory to the patient's bedside, the patient's home, and other non-laboratory sites. This is called POCT (also known as ancillary or waived testing) and can include tests for blood glucose, fecal occult blood, hemoglobin, and pro-thrombin time.

All laboratory testing performed in VHA facilities must adhere to quality testing practices. These practices include annual competency assessment and quality control testing. Failure to implement and comply with regulatory standards and quality testing practices can jeopardize patient safety and place VHA facilities at risk. Erroneous results can lead to inaccurate diagnoses, inappropriate medical treatment, and poor patient outcomes.[22]

We reviewed relevant documents, the EHRs of 50 randomly selected inpatients and outpatients who underwent POCT for blood glucose from July 1, 2015 through June 30, 2016, and the annual competency assessment of the clinician who performed the glucose testing. Additionally, we interviewed key employees and conducted onsite glucometer inspections of the intensive care unit, post-anesthesia care unit, medical/surgical/telemetry unit (5N), and the oncology outpatient clinic at the Cooper Division and the Hazard/Perry County CBOC to assess compliance with manufacturers' maintenance and solution/reagent storage requirements. The table below shows the areas reviewed for this topic. The facility generally met requirements. We made no recommendations.

Checklist 5. Diagnostic Care: POCT Areas Reviewed, Findings, and Recommendations

NM	Areas Reviewed	Findings	Recommendations
	The facility had a policy delineating requirements for the POCT program and required oversight by the Chief of Pathology and Laboratory Medicine Service.		
	The facility had a designated POCT/Ancillary Testing Coordinator.		

[22] The Joint Commission. *Comprehensive Accreditation Manual for Laboratories and Point-of-Care Testing*. Update 2. September 2010.

NM	Areas Reviewed (continued)	Findings	Recommendations
	The Chief of Pathology and Laboratory Medicine Service approved all tests performed outside the main laboratory.		
	The facility had a process to ensure employee competency for POCT with glucometers and evaluated competencies at least annually.		
	The facility required documentation of POCT results in the EHR.		
	A regulatory agency accredited the facility's POCT program.		
	Clinicians documented test results in the EHR.		
	Clinicians initiated appropriate clinical action and follow-up for test results.		
	The facility had POCT procedure manuals readily available to employees.		
	Quality control testing solutions/reagents and glucose test strips were current (not expired).		
	The facility managed and performed quality control in accordance with its policy/standard operating procedure and manufacturer's recommendations.		
	Glucometers were clean.		

Moderate Sedation

The purpose of this review was to evaluate selected aspects of care to determine whether the facility complied with applicable policies in the provision of moderate sedation.[f] During calendar year 2016, VHA clinicians performed more than 600,000 moderate sedation procedures of which more than half were gastroenterology-related endoscopies.[23] Moderate sedation is a drug-induced depression of consciousness during which patients are able to respond to verbal commands. Non-anesthesiologists administer sedatives and analgesics to relieve anxiety and increase patient comfort during invasive procedures and usually do not have to provide interventions to maintain a patent airway, spontaneous ventilations, or cardiovascular function.[24] However, serious adverse events can occur, including cardiac and respiratory depression, brain damage due to low oxygen levels, cardiac arrest, or death. To minimize risks, VHA and The Joint Commission have issued requirements and standards for moderate sedation care.

We reviewed relevant documents; interviewed key employees; and inspected the gastroenterology, cardiology, interventional radiology, intensive care unit, progressive care unit, and Emergency Department procedure rooms/areas at the Cooper Division and the dental procedure rooms/areas at the Cooper and Leestown Divisions to assess whether required equipment and sedation medications were available. Additionally, we reviewed the EHRs of 49 randomly selected patients who underwent an invasive procedure involving moderate sedation from July 1, 2015 through June 30, 2016, and the training records of 19 clinical employees who performed or assisted during these procedures. The table below shows the areas reviewed for this topic. The areas marked as NM did not meet applicable requirements and needed improvement.

Checklist 6. Moderate Sedation Areas Reviewed, Findings, and Recommendations

NM	Areas Reviewed	Findings	Recommendations
	The facility reported and trended the use of reversal agents in moderate sedation cases, processed adverse events/complications in a similar manner as operating room anesthesia adverse events, and noted the absence of adverse events in Moderate Sedation Committee reports.		

[23] Per VA Corporate Data Warehouse data pull on February 22, 2017.
[24] American Society of Anesthesiologists. Practice Guidelines for Sedation and Analgesia by Non-Anesthesiologists. *Anesthesiology*. 2002; 96:1004.

NM	Areas Reviewed (continued)	Findings	Recommendations
	Providers performed history and physical examinations within 30 calendar days prior to the moderate sedation procedure, and the history and physical and the pre-sedation assessment in combination included required elements.		
	Providers re-evaluated patients immediately before moderate sedation for changes since the prior assessment.		
	Providers documented informed consent prior to moderate sedation procedures, and the name of provider listed on the consent was the same as the provider who performed the procedure, or the patient was notified of the change.		
	The clinical team, including the provider performing the procedure, conducted and documented a timeout prior to the moderate sedation procedure.		
	Post-procedure documentation included assessments of patient mental status and pain level.		
X	Clinical employees discharged outpatients from the recovery area with orders from the provider who performed the procedure or according to criteria approved by moderate sedation clinical leaders.	• In 4 of 37 EHRs (11 percent), there was no evidence that clinical staff discharged outpatients from the recovery area appropriately.	**16.** We recommended that clinical employees discharge outpatients from the recovery area according to provider orders or criteria approved by moderate sedation clinical leaders and that clinical managers monitor compliance.
	Clinical employees discharged moderate sedation outpatients in the company of a responsible adult.		

NM	Areas Reviewed (continued)	Findings	Recommendations
X	Selected clinical employees had current training for moderate sedation.	• In 9 of 19 employee training records, there was no documentation of current training for moderate sedation.	**17.** We recommended that clinical managers ensure that clinical employees who perform or assist with moderate sedation have current training for the provision of moderate sedation care and that training is documented and monitor compliance.
	The clinical team kept monitoring and resuscitation equipment and reversal agents in the general areas where moderate sedation was administered.		
	To minimize risk, clinical employees did not store anesthetic agents in procedure rooms/areas where only moderate sedation procedures were performed by licensed independent practitioners who do not have the training and ability to rescue a patient from general anesthesia.		

Community Nursing Home Oversight

The purpose of this review was to assess whether the facility complied with applicable requirements regarding the monitoring of veterans in contracted CNHs.[g] Since 1965, VHA has provided nursing home care under contracts. VHA facilities must integrate the CNH program into their quality improvement programs. The Facility Director establishes the CNH Oversight Committee, which reports to the chief clinical officer (Chief of Staff, Associate Director for Patient Care Services, or the equivalent) and includes multidisciplinary management-level representatives from social work, nursing, quality management, acquisition, and the medical staff. The CNH Oversight Committee must meet at least quarterly.[25] Local oversight of CNHs is achieved through annual reviews and monthly visits.

We reviewed relevant documents, the EHRs of 37 patients who received CNH care for more than 3 months during the timeframe July 1, 2015 through June 30, 2016, and the results from CNH annual reviews completed July 5, 2015 through June 30, 2016. Additionally, we interviewed key employees. The table below shows the areas reviewed for this topic. The areas marked as NM did not meet applicable requirements and needed improvement.

Checklist 7. CNH Oversight Areas Reviewed, Findings, and Recommendations

NM	Areas Reviewed	Findings	Recommendations
X	The facility had a CNH Oversight Committee that met at least quarterly and included representation by the required disciplines.	• The facility's CNH Oversight Committee did not include a representative from acquisitions.	**18.** We recommended that facility managers ensure the Community Nursing Home Oversight Committee includes representation by all required disciplines.
X	The facility integrated the CNH program into its quality improvement program.	• The executive-level committee meeting minutes did not contain documentation of the CNH program's integration into its quality improvement program.	**19.** We recommended that the facility ensure integration of the community nursing home program into its quality improvement program.
	The facility documented a hand-off for patients placed in CNHs outside of its catchment area.		
	The CNH Review Team completed CNH annual reviews.		

[25] VHA Handbook 1143.2, *VHA Community Nursing Home Oversight Procedures*, June 4, 2004.

NM	Areas Reviewed (continued)	Findings	Recommendations
	When CNH annual reviews noted four or more exclusionary criteria, facility managers completed exclusion review documentation.		
X	Social workers and registered nurses documented clinical visits that alternated on a cyclical basis.	• In 9 of the 37 EHRs (24 percent), there was no documentation of registered nurse cyclical clinical visits with the frequency required by VHA policy. These 9 patients were spread out among 7 of the 12 CNHs in our review.	**20.** We recommended that facility managers ensure that registered nurses conduct and document cyclical clinical visits with the frequency required by Veterans Health Administration policy for community nursing home oversight and monitor compliance.

Management of Disruptive/Violent Behavior

The purpose of this review was to determine the extent to which the facility complied with selected requirements in the management of disruptive and violent behavior.[h] VHA policy states a commitment to reducing and preventing disruptive behaviors and other defined acts that threaten public safety through the development of policy, programs, and initiatives aimed at patient, visitor, and employee safety. In addition, Public Law 112-154, section 106 directed VA to develop and implement a comprehensive policy on the reporting and tracking of public safety incidents that occur at each medical facility.

We reviewed relevant documents, the EHRs of 41 randomly selected patients who exhibited disruptive or violent behavior, and 2 reports of disruptive/violent non-patient related incidents that occurred during the timeframe July 1, 2015 through June 30, 2016, and the training records of 30 recently hired employees who worked in areas at low, moderate, or high risk for violence. Additionally, we interviewed key employees. The table below shows the areas reviewed for this topic. The areas marked as NM did not meet applicable requirements and needed improvement.

Checklist 8. Management of Disruptive/Violent Behavior Areas Reviewed, Findings, and Recommendations

NM	Areas Reviewed	Findings	Recommendations
	The facility had a policy, procedure, or guideline on preventing and managing disruptive or violent behavior.		
	The facility conducted an annual Workplace Behavioral Risk Assessment.		
	The facility had implemented: • An Employee Threat Assessment Team or acceptable alternate group • A Disruptive Behavior Committee with appropriate membership • A disruptive behavior reporting and tracking system		
	The facility collected and analyzed disruptive or violent behavior incidents data.		
	The facility assessed physical security and included and tested equipment in accordance with the local physical security assessment.		

NM	Areas Reviewed (continued)	Findings	Recommendations
X	Clinical managers reviewed patients' disruptive or violent behavior and took appropriate actions, including: • Ensuring discussion by the Disruptive Behavior Committee/Board and entry of a progress note by a clinician committee/board member • Informing patients about Patient Record Flag placement and the right to request to amend/appeal the flag placement • Ensuring Chief of Staff or designee approval of an Order of Behavioral Restriction	• In 5 of 12 EHRs, there was no evidence that clinicians informed patients about the Patient Record Flag and their right to request to amend/appeal Patient Record Flag placement.	**21.** We recommended that facility clinical managers ensure clinicians inform patients about the Patient Record Flags and the right to request to amend/appeal flag placement and monitor compliance.
	When a Patient Record Flag was placed for an incident of disruptive behavior in the past, a clinician reviewed the continuing need for the flag within the past 2 years.		
	The facility managed selected non-patient related disruptive or violent incidents appropriately according to VHA and local policy.		
X	The facility had a security training plan for employees at all risk levels. • All employees received Level 1 training within 90 days of hire. • All employees received additional training as required for the assigned risk area within 90 days of hire.	• In 12 of 30 employee training records (40 percent), there was no documentation of Level 1 training within 90 days of hire. • Twenty-eight of 30 employee training records (93 percent) did not contain documentation of the training required for their assigned risk area within 90 days of hire.	**22.** We recommended that facility managers ensure all employees receive Level 1 Prevention and Management of Disruptive Behavior training and additional training as required for their assigned risk area within 90 days of hire, ensure the training is documented in employee training records, and monitor compliance.

Mental Health Residential Rehabilitation Treatment Program

The purpose of this review was to determine whether the facility's MH RRTPs (more commonly referred to as domiciliary or residential treatment programs) complied with selected EOC requirements. The Domiciliary Care for Homeless Veterans Program was established through legislation in the late 1860s with the purpose of providing a home for disabled volunteer soldiers of the Civil War. In 1995, VA established the Psychosocial RRTP bed level of care. This distinct level of MH residential care is appropriate for veterans with mental illnesses or addictive disorders who require structure and support to address psychosocial deficits, including homelessness and unemployment. In 2005, the Domiciliary RRTP was fully integrated with other RRTPs of the Office of MH Services.[i]

We reviewed relevant documents; inspected the Substance Abuse and the Post-Traumatic Stress Disorder RRTPs at the Leestown Division; and interviewed 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.

Checklist 9. MH RRTP Areas Reviewed, Findings, and Recommendations

NM	Areas Reviewed	Findings	Recommendations
	The residential environment was clean and in good repair.		
NA	Appropriate fire extinguishers were available near grease producing cooking devices.		
	There were policies/procedures that addressed safe medication management and contraband detection.		
X	MH RRTP employees conducted and documented monthly self-inspections that included all required elements, submitted work orders for items needing repair, and ensured correction of any identified deficiencies.	Six months of self-inspection documentation reviewed: • Substance Abuse and Post-Traumatic Stress Disorder RRTP monthly self-inspection documentation did not include assessment of privacy.	**23.** We recommended that Substance Abuse and Post-Traumatic Stress Disorder Residential Rehabilitation Treatment Program monthly self-inspections include assessment of privacy and that facility managers monitor compliance.
	MH RRTP employees conducted and documented contraband inspections, rounds of all public spaces, daily bed checks, and resident room inspections for unsecured medications.		

NM	Areas Reviewed (continued)	Findings	Recommendations
	The MH RRTP had written agreements in place acknowledging resident responsibility for medication security.		
	The 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 had 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.		
	In mixed gender MH RRTP units, women veterans' rooms had keyless entry or door locks.		
	Residents secured medications in their rooms.		

Review Area with Previous Combined Assessment Program Review Recommendation

Panic Alarm Testing

As a follow-up to a recommendation from our prior Combined Assessment Program review, we reassessed facility compliance with panic alarm testing on the locked MH unit.[j]

Panic Alarm Testing. VHA requires panic alarms on the locked MH unit to be tested and to include VA Police response time. During our previous Combined Assessment Program review, we found no documentation of panic alarm testing for the group room for the 4 months reviewed. During this review, we found documented evidence of panic alarm testing during the month of January 2017, but documentation did not include VA Police response time.

Recommendation

24. We recommended that facility managers ensure locked mental health unit panic alarm testing includes VA Police response time and monitor compliance.

Facility Profile

Table 1 below provides general background information for this facility.

Table 1. Facility Profile for Lexington (596) for FY 2016

Profile Element	Facility Data
Veterans Integrated Service Network Number	9
Complexity Level	1b-High complexity
Affiliated/Non-Affiliated	Affiliated
Total Medical Care Budget in Millions	$349.0
Number of:	
• **Unique Patients**	37,045
• **Outpatient Visits**	507,086
• **Unique Employees**[26]	1,820
Type and Number of Operating Beds:	
• **Acute**	79
• **MH**	33
• **Community Living Center**	61
• **Domiciliary**	30
Average Daily Census:	
• **Acute**	58
• **MH**	10
• **Community Living Center**	42
• **Domiciliary**	22

Source: VA Office of Academic Affiliations, VHA Support Service Center, and VA Corporate Data Warehouse

Note: We did not assess VA's data for accuracy or completeness.

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

VA Outpatient Clinic Profiles[27]

The VA outpatient clinics in the communities within the catchment area of the facility provide PC integrated with women's health, MH, and telehealth services. Some also provide specialty care, diagnostic, and ancillary services. Table 2 below provides information relative to each of the clinics.

Table 2. VA Outpatient Clinic Workload/Encounters[28] and Specialty Care, Diagnostic, and Ancillary Services Provided for FY 2016

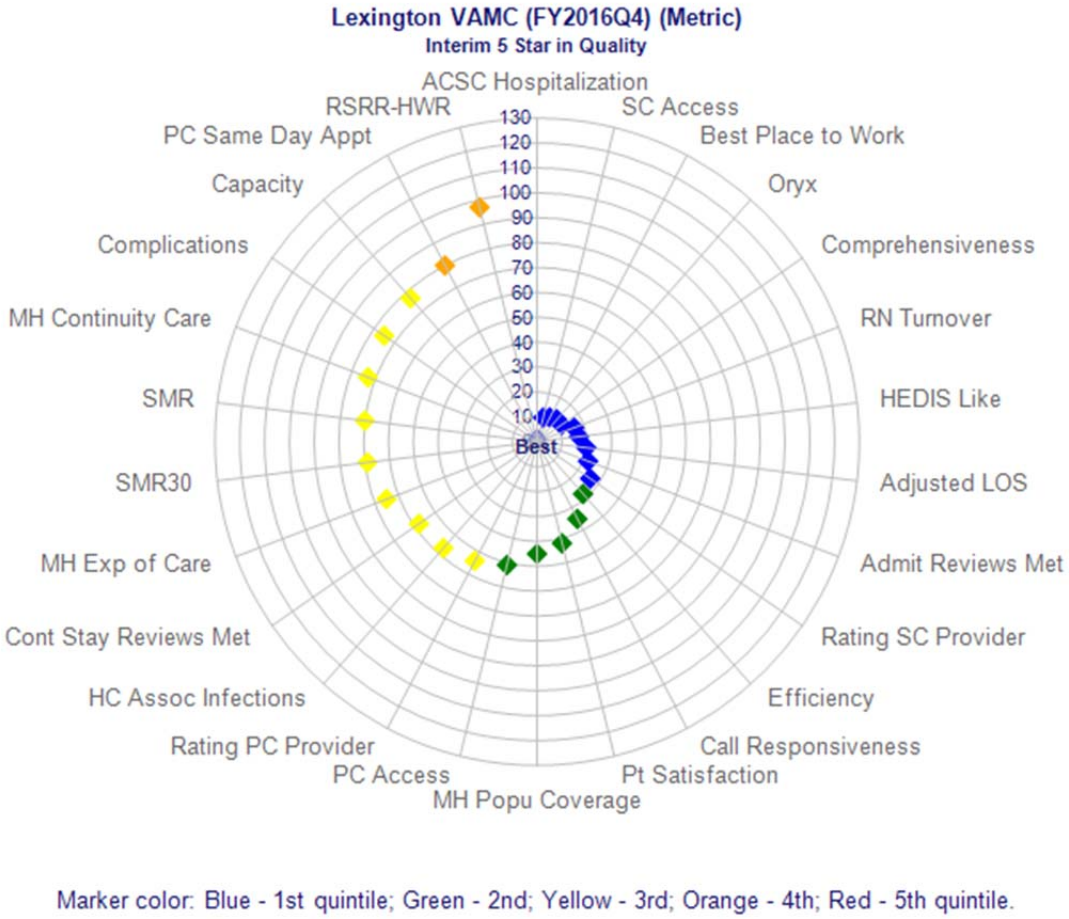
Location	Station No.	PC Workload/ Encounters	MH Workload/ Encounters	Specialty Care Services[29] Provided	Diagnostic Services[30] Provided	Ancillary Services[31] Provided
Somerset, KY	596GA	12,479	3,618	Cardiology Dermatology Gastroenterology Nephrology Anesthesia Podiatry Urology	NA	Nutrition Pharmacy Social Work Weight Management
Morehead, KY	596GB	5,034	926	Dermatology Gastroenterology Anesthesia Podiatry Urology	NA	Nutrition Pharmacy Social Work Weight Management
Hazard, KY	596GC	4,796	2,084	Cardiology Dermatology Anesthesia Podiatry Urology	NA	Nutrition Pharmacy
Berea, KY	596GD	8,345	1,105	Cardiology Dermatology Poly-Trauma Anesthesia General Surgery Podiatry Urology	NA	Nutrition Pharmacy Weight Management

Source: VHA Support Service Center and VA Corporate Data Warehouse

Note: We did not assess VA's data for accuracy or completeness.

[27] Includes all outpatient clinics in the community that were in operation before February 15, 2016. We have omitted Corbin, KY (596QA) as no workload/encounters or services were reported.
[28] An encounter is a professional contact between a patient and a practitioner vested with responsibility for diagnosing, evaluating, and treating the patient's condition.
[29] Specialty care services refer to non-PC and non-MH services provided by a physician.
[30] Diagnostic services include EKG, EMG, laboratory, nuclear medicine, radiology, and vascular lab services.
[31] Ancillary services include chiropractic, dental, nutrition, pharmacy, prosthetic, social work, and weight management services.

Strategic Analytics for Improvement and Learning (SAIL)[32]

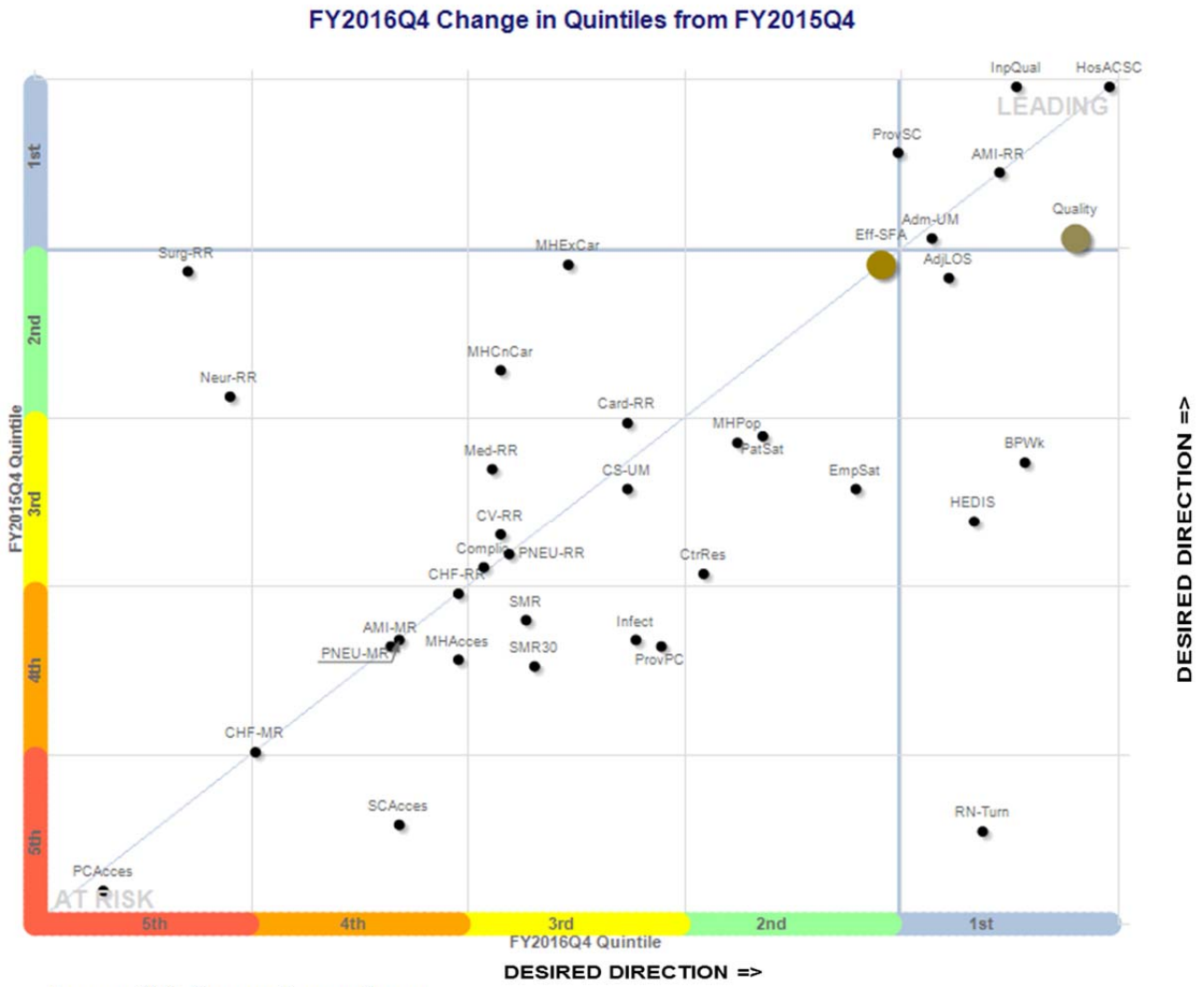


Source: VHA Support Service Center

Note: We did not assess VA's data for accuracy or completeness.

[32] 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.

Source: VHA Support Service Center

Note: We did not assess VA's data for accuracy or completeness.

Metric Definitions[k]

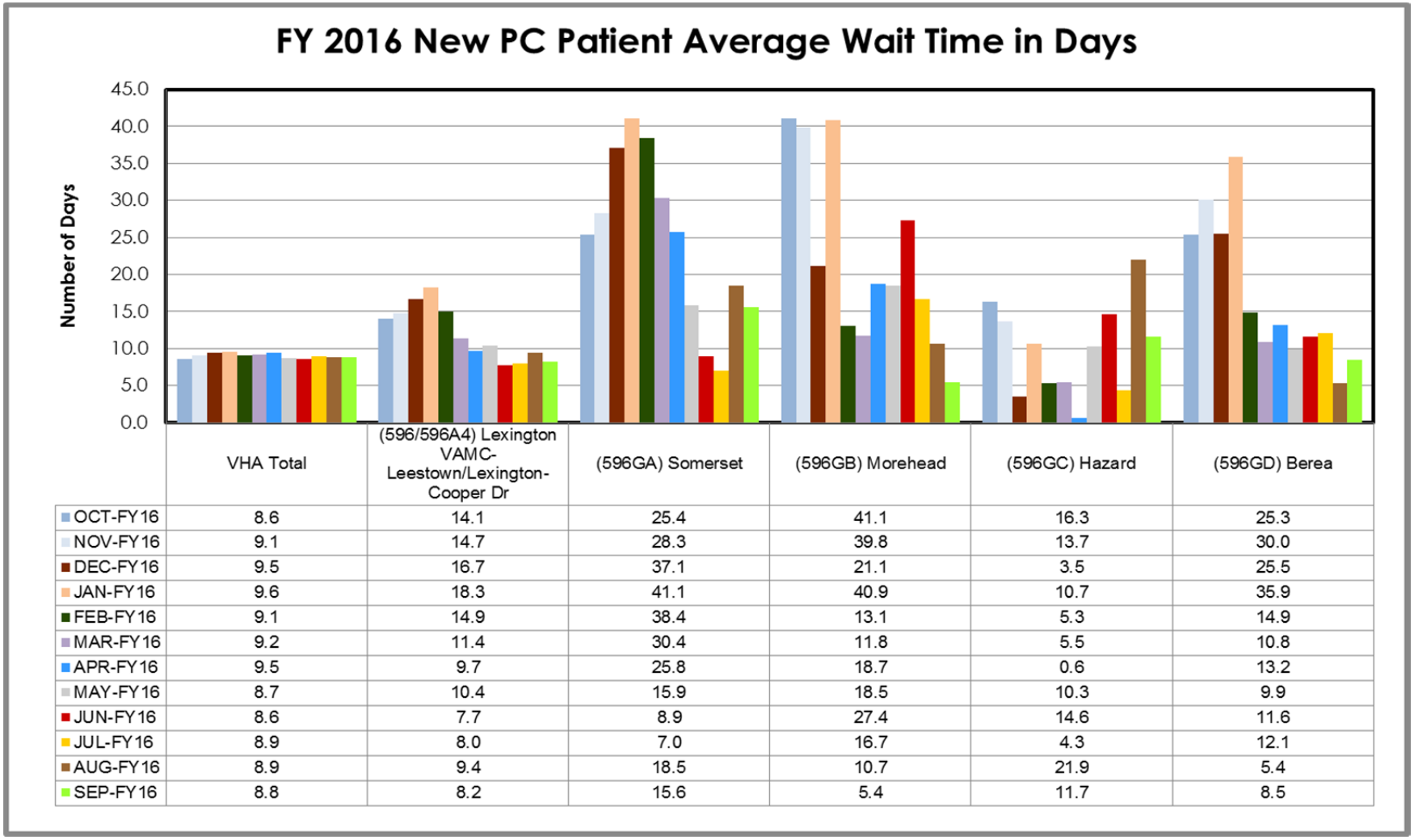
Measure	Definition	Desired Direction
ACSC Hospitalization	Ambulatory care sensitive condition hospitalizations (observed to expected ratio)	A lower value is better than a higher value
Adjusted LOS	Acute care risk adjusted length of stay	A lower value is better than a higher value
Admit Reviews Met	% Acute Admission Reviews that meet InterQual criteria	A higher value is better than a lower 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
Cont Stay Reviews Met	% Acute Continued Stay reviews that meet InterQual criteria	A higher value is better than a lower 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 Like	Outpatient performance measure (HEDIS)	A higher value is better than a lower value
MH Wait Time	MH care wait time for new patient completed appointments within 30 days of preferred date	A higher value is better than a lower value
MH Continuity Care	MH continuity of care (FY14Q3 and later)	A higher value is better than a lower value
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
PC Routine Care Appt	Timeliness in getting a PC routine care appointment (PCMH)	A higher value is better than a lower value
PC Urgent Care Appt	Timeliness in getting a PC urgent care appointment (PCMH)	A higher value is better than a lower value
PC Wait Time	PC wait time for new patient completed appointments within 30 days of preferred date	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
Rating PC Provider	Rating of PC providers (PCMH)	A higher value is better than a lower value
Rating SC Provider	Rating of specialty care providers (specialty care module)	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

Measure	Definition	Desired Direction
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-Cardio	30-day risk standardized readmission rate for cardiorespiratory patient cohort	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-CV	30-day risk standardized readmission rate for cardiovascular patient cohort	A lower value is better than a higher value
RSRR-HWR	Hospital wide readmission	A lower value is better than a higher value
RSRR-Med	30-day risk standardized readmission rate for medicine patient cohort	A lower value is better than a higher value
RSRR-Neuro	30-day risk standardized readmission rate for neurology patient cohort	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
RSRR-Surg	30-day risk standardized readmission rate for surgery patient cohort	A lower value is better than a higher value
SC Routine Care Appt	Timeliness in getting a SC routine care appointment (Specialty Care)	A higher value is better than a lower value
SC Urgent Care Appt	Timeliness in getting a SC urgent care appointment (Specialty Care)	A higher value is better than a lower 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 patient completed appointments within 30 days of preferred date	A higher value is better than a lower value

Source: VHA Support Service Center

Note: We did not assess VA's data for accuracy or completeness.

Patient Aligned Care Team Compass Metrics

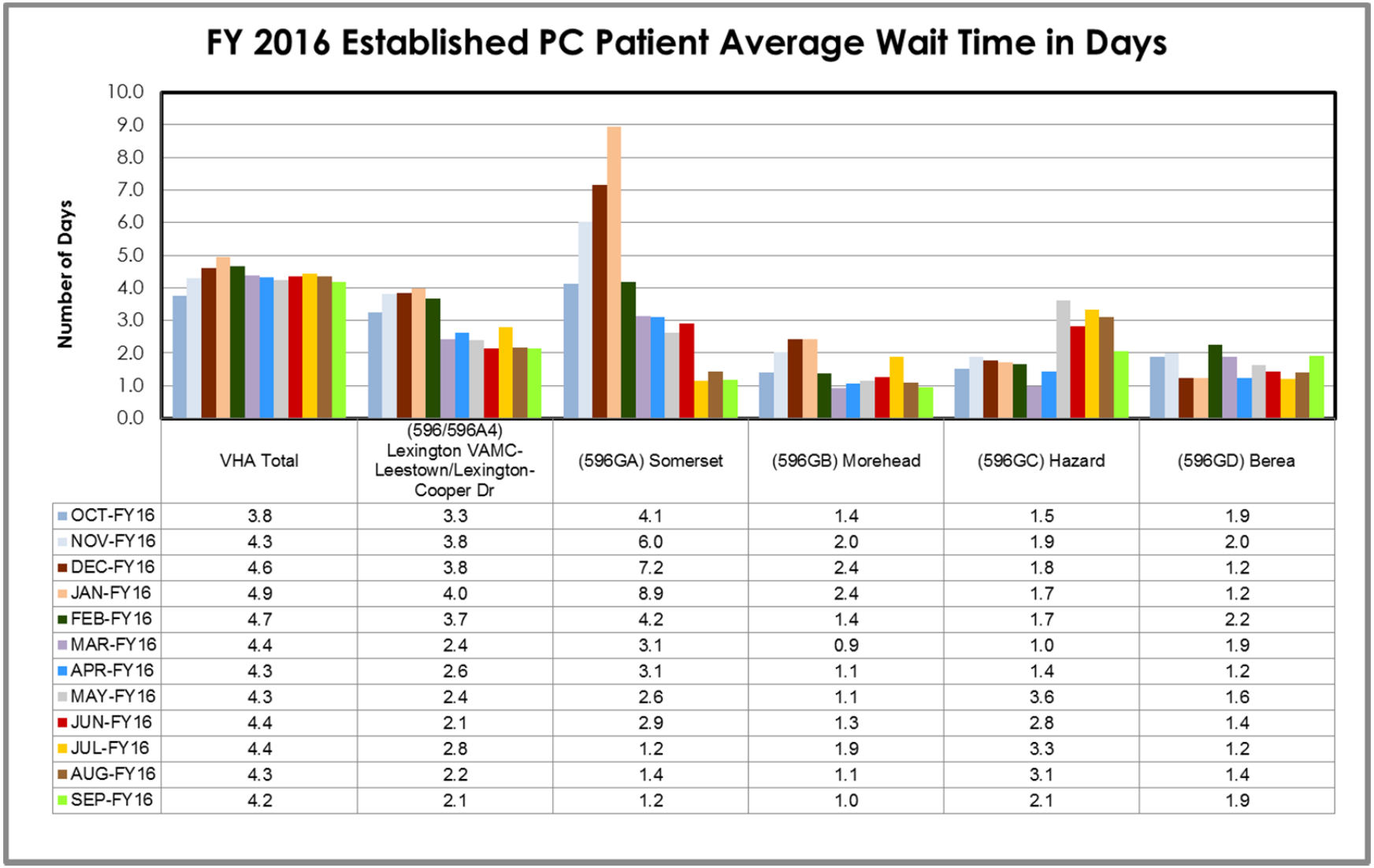


	VHA Total	(596/596A4) Lexington VAMC-Leestown/Lexington-Cooper Dr	(596GA) Somerset	(596GB) Morehead	(596GC) Hazard	(596GD) Berea
OCT-FY16	8.6	14.1	25.4	41.1	16.3	25.3
NOV-FY16	9.1	14.7	28.3	39.8	13.7	30.0
DEC-FY16	9.5	16.7	37.1	21.1	3.5	25.5
JAN-FY16	9.6	18.3	41.1	40.9	10.7	35.9
FEB-FY16	9.1	14.9	38.4	13.1	5.3	14.9
MAR-FY16	9.2	11.4	30.4	11.8	5.5	10.8
APR-FY16	9.5	9.7	25.8	18.7	0.6	13.2
MAY-FY16	8.7	10.4	15.9	18.5	10.3	9.9
JUN-FY16	8.6	7.7	8.9	27.4	14.6	11.6
JUL-FY16	8.9	8.0	7.0	16.7	4.3	12.1
AUG-FY16	8.9	9.4	18.5	10.7	21.9	5.4
SEP-FY16	8.8	8.2	15.6	5.4	11.7	8.5

Source: VHA Support Service Center

Note: We did not assess VA's data for accuracy or completeness.

Data Definition[l]: The average number of calendar days between a new patient's PC completed appointment (clinic stops 322, 323, and 350, excluding Compensation and Pension appointments) and the earliest of three possible preferred (desired) dates (Electronic Wait List (EWL), Cancelled by Clinic Appointment, Completed Appointment) from the completed appointment date. *Note that prior to FY 2015, this metric was calculated using the earliest possible create date.* Note: The Lexington VAMC-Leestown column includes data for the Lexington-Cooper division.

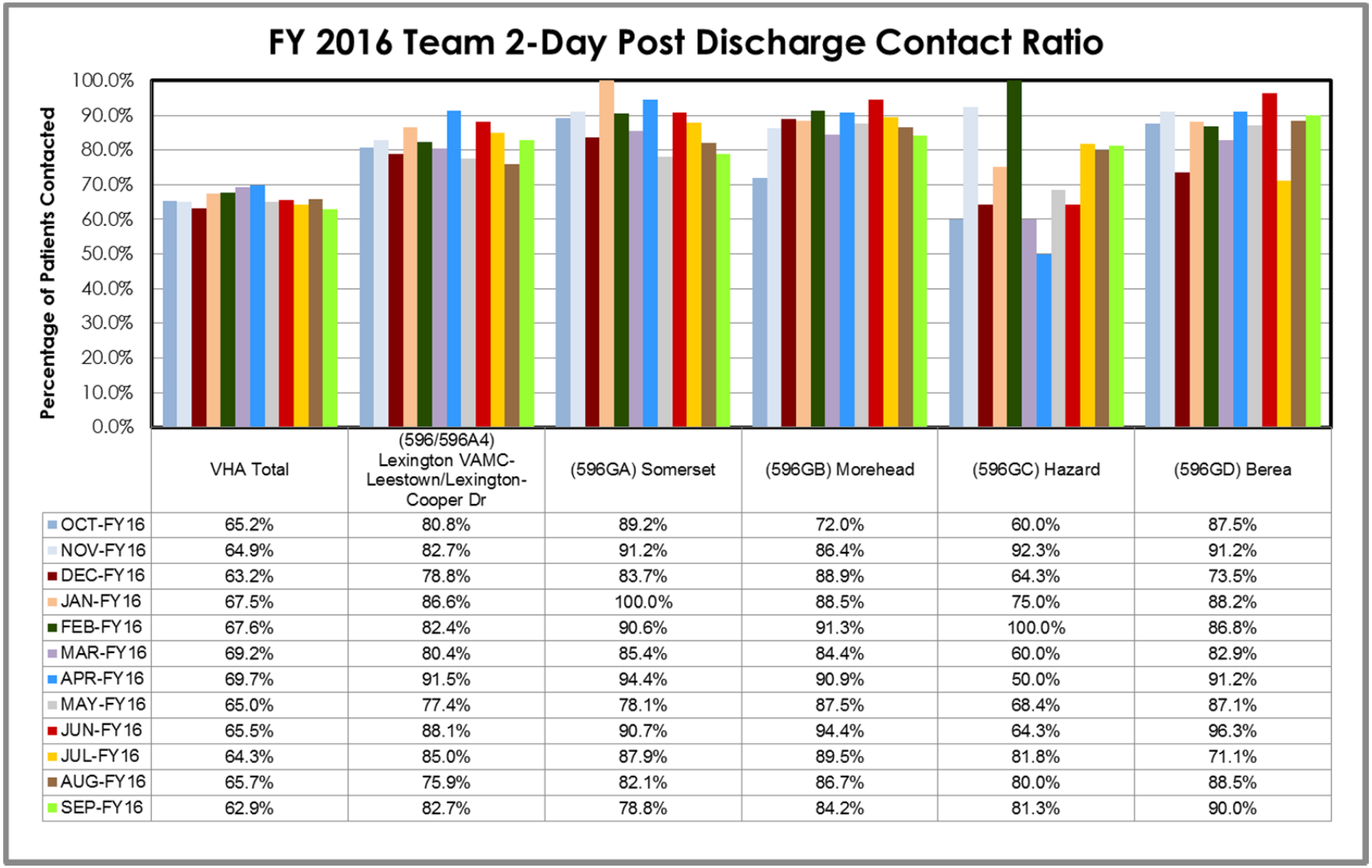


	VHA Total	(596/596A4) Lexington VAMC-Leestown/Lexington-Cooper Dr	(596GA) Somerset	(596GB) Morehead	(596GC) Hazard	(596GD) Berea
OCT-FY16	3.8	3.3	4.1	1.4	1.5	1.9
NOV-FY16	4.3	3.8	6.0	2.0	1.9	2.0
DEC-FY16	4.6	3.8	7.2	2.4	1.8	1.2
JAN-FY16	4.9	4.0	8.9	2.4	1.7	1.2
FEB-FY16	4.7	3.7	4.2	1.4	1.7	2.2
MAR-FY16	4.4	2.4	3.1	0.9	1.0	1.9
APR-FY16	4.3	2.6	3.1	1.1	1.4	1.2
MAY-FY16	4.3	2.4	2.6	1.1	3.6	1.6
JUN-FY16	4.4	2.1	2.9	1.3	2.8	1.4
JUL-FY16	4.4	2.8	1.2	1.9	3.3	1.2
AUG-FY16	4.3	2.2	1.4	1.1	3.1	1.4
SEP-FY16	4.2	2.1	1.2	1.0	2.1	1.9

Source: VHA Support Service Center

Note: We did not assess VA's data for accuracy or completeness.

Data Definition: The average number of calendar days between an established patient's PC completed appointment (clinic stops 322, 323, and 350, excluding Compensation and Pension appointments) and the earliest of three possible preferred (desired) dates (Electronic Wait List (EWL), Cancelled by Clinic Appointment, Completed Appointment) from the completed appointment date. Note: The Lexington VAMC-Leestown column includes data for the Lexington-Cooper division.

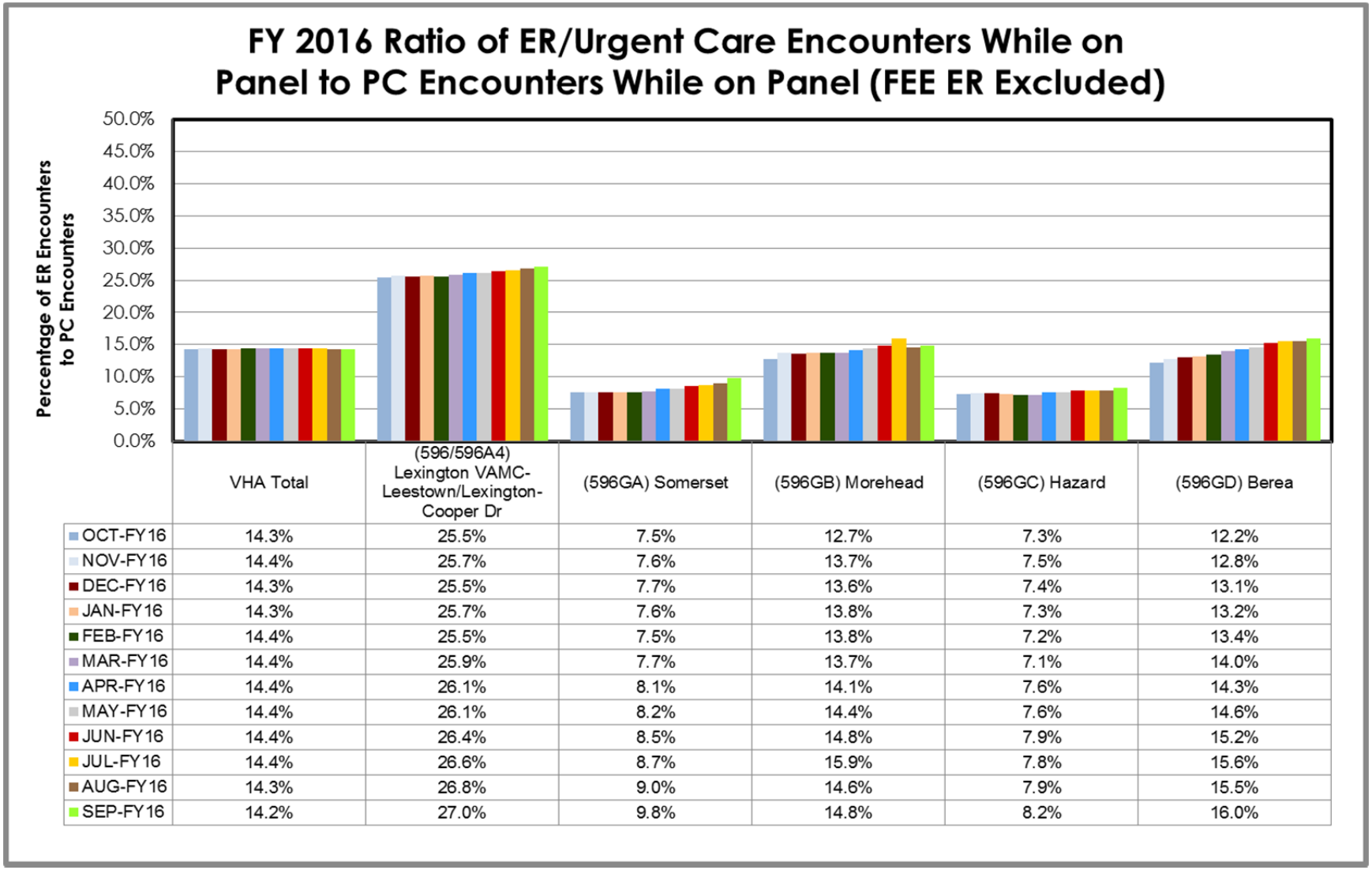


	VHA Total	(596/596A4) Lexington VAMC-Leestown/Lexington-Cooper Dr	(596GA) Somerset	(596GB) Morehead	(596GC) Hazard	(596GD) Berea
OCT-FY16	65.2%	80.8%	89.2%	72.0%	60.0%	87.5%
NOV-FY16	64.9%	82.7%	91.2%	86.4%	92.3%	91.2%
DEC-FY16	63.2%	78.8%	83.7%	88.9%	64.3%	73.5%
JAN-FY16	67.5%	86.6%	100.0%	88.5%	75.0%	88.2%
FEB-FY16	67.6%	82.4%	90.6%	91.3%	100.0%	86.8%
MAR-FY16	69.2%	80.4%	85.4%	84.4%	60.0%	82.9%
APR-FY16	69.7%	91.5%	94.4%	90.9%	50.0%	91.2%
MAY-FY16	65.0%	77.4%	78.1%	87.5%	68.4%	87.1%
JUN-FY16	65.5%	88.1%	90.7%	94.4%	64.3%	96.3%
JUL-FY16	64.3%	85.0%	87.9%	89.5%	81.8%	71.1%
AUG-FY16	65.7%	75.9%	82.1%	86.7%	80.0%	88.5%
SEP-FY16	62.9%	82.7%	78.8%	84.2%	81.3%	90.0%

Source: VHA Support Service Center

Note: We did not assess VA's data for accuracy or completeness.

Data Definition: The percent of assigned PC patients discharged from any VA facility who have been contacted by a PC team member within 2 business days during the reporting period. Patients are excluded if they are discharged from an observation specialty and/or readmitted within 2 business days to any VA facility. Team members must have been assigned to the patient's team at the time of the patient's discharge. Note: The Lexington VAMC-Leestown column includes data for the Lexington-Cooper division.



	VHA Total	(596/596A4) Lexington VAMC-Leestown/Lexington-Cooper Dr	(596GA) Somerset	(596GB) Morehead	(596GC) Hazard	(596GD) Berea
OCT-FY16	14.3%	25.5%	7.5%	12.7%	7.3%	12.2%
NOV-FY16	14.4%	25.7%	7.6%	13.7%	7.5%	12.8%
DEC-FY16	14.3%	25.5%	7.7%	13.6%	7.4%	13.1%
JAN-FY16	14.3%	25.7%	7.6%	13.8%	7.3%	13.2%
FEB-FY16	14.4%	25.5%	7.5%	13.8%	7.2%	13.4%
MAR-FY16	14.4%	25.9%	7.7%	13.7%	7.1%	14.0%
APR-FY16	14.4%	26.1%	8.1%	14.1%	7.6%	14.3%
MAY-FY16	14.4%	26.1%	8.2%	14.4%	7.6%	14.6%
JUN-FY16	14.4%	26.4%	8.5%	14.8%	7.9%	15.2%
JUL-FY16	14.4%	26.6%	8.7%	15.9%	7.8%	15.6%
AUG-FY16	14.3%	26.8%	9.0%	14.6%	7.9%	15.5%
SEP-FY16	14.2%	27.0%	9.8%	14.8%	8.2%	16.0%

Source: VHA Support Service Center

Note: We did not assess VA's data for accuracy or completeness.

Data Definition: This is a measure of where the patient receives his PC and by whom. A low percentage is better. The formula is the total VHA ER/Urgent Care Encounters While on Team (WOT) with a Licensed Independent Practitioner (LIP) *divided by* the number of PC Team Encounters WOT with an LIP **plus** the total number of VHA ER/Urgent Care Encounters WOT with an LIP. Note: The Lexington VAMC-Leestown column includes data for the Lexington-Cooper division.

Prior OIG Reports
March 1, 2014 through March 1, 2017

Facility Reports

Healthcare Inspection – Review of the Operations and Effectiveness of VHA Residential Substance Use Treatment Programs
7/30/2015 | 15-01579-457 | Summary | Report

Community Based Outpatient Clinics Summary Report – Evaluation of Medication Oversight and Education at Community Based Outpatient Clinics and Other Outpatient Clinics
6/18/2015 | 15-01297-368 | Summary | Report

Appendix E

Acting Veterans Integrated Service Network Director Comments

Department of Veterans Affairs

Memorandum

Date: May 26, 2017

From: Interim Director, VA MidSouth Healthcare Network (10N9)

Subject: **CAP Review of the Lexington VA Medical Center, Lexington, KY**

To: Associate Director, Bay Pines Office of Healthcare Inspections (54SP)

Director, Management Review Service (VHA 10E1D MRS Action)

1. Thank you for conducting a comprehensive review of the Lexington VA Medical Center (VAMC), Lexington, KY.

2. I have reviewed the document and concur with the response as submitted.

Facility Director Comments

Department of Veterans Affairs

Memorandum

Date: May 26, 2017

From: Director, Lexington VA Medical Center (596/00)

Subject: **CAP Review of the Lexington VA Medical Center, Lexington, KY**

To: Acting Director, VA MidSouth Healthcare Network (10N9)

1. Thank you for the opportunity to review and respond to the Clinical Assessment Program Review. I concur with the findings and recommendations.

2. Our responses to the report recommendations are attached. We have been actively working on improvements. We appreciate the perspective from the Office of Inspector General evaluation and will take this opportunity to strengthen and improve our medical center processes.

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 Physician Utilization Management Advisors consistently document their decisions in the National Utilization Management Integration database and that facility managers monitor compliance.

Concur

Target date for completion: 09/01/2017

Facility response: On March 20, 2017 a Service Agreement between Utilization Management and the medical staff, defining the Physician Utilization Management Advisor review exclusion criteria, was approved by Medical Executive Council. The Utilization Management Director conducted three Physician Utilization Management Advisor training sessions in March for designated Physician Utilization Managers. Monday through Friday the Utilization Management Nurse sends notification to the Physician Utilization Managers to inform them of pending cases requiring second level review. Each week the Utilization Management Director reviews pending cases requiring second level review. Bimonthly the Utilization Manager Director conducts and audit of the Physician Utilization Management Advisor compliance rate and distributes findings to the Medical Service Chiefs and Chief of Staff. The Physician Utilization Management Advisor compliance rate will be reported monthly to the Quality, Safety, and Value Council on a monthly basis until 90 percent compliance is maintained for three consecutive months.

Recommendation 2. We recommended that the Infection Control Committee document analysis of surveillance data related to follow-up activities for the hemodialysis unit and Sterile Processing Service areas.

Concur

Target date for completion: 09/01/2017

Facility response: On May 23, 2017 surveillance data surrounding follow-up actions for the Hemodialysis Unit and Sterile Processing Service that has the potential to increase the risk of acquiring and transmitting of infections were reported during the Infection Control Committee meeting. The surveillance data surrounding follow-up actions will be reported monthly to the Infection Control Committee. Infection Control will monitor minutes for compliance and report data to the Quality, Safety, and Value Council until 90 percent compliance is maintained for three consecutive months.

Recommendation 3. We recommended that facility managers at the Cooper Division implement the use of a visitors log during non-business hours and monitor compliance.

Concur

Target date for completion: 07/01/2017

Facility response: On February 11, 2017 visitor registration forms were placed at the Administrator Officer of the Day desk at Cooper Drive. Registration forms are collected monthly by VA Police. VA Police monitor and report monthly to the Environment of Care Committee to ensure 90 percent compliance for three months.

Recommendation 4. We recommended that facility managers at the Cooper Division ensure ceiling ventilation grills in patient care areas are clean and monitor compliance.

Concur

Target date for completion: 07/01/2017

Facility response: All ceiling ventilation grills were cleaned by February 13, 2017. Environmental Management Service conducted weekly inspections of 25 vents, until 90 percent were found to be free of dust and debris for four consecutive weeks, then monitored 25 vents monthly thereafter. Environmental Management Service reported 90 percent compliance to the Environment of Care Committee on May 11, 2017 for March and April. Results will continue to be reported monthly to Environment of Care Committee until 90 percent compliance for three consecutive months. Ongoing compliance will be monitored monthly by Environment Management Service Supervisor by utilizing the Environment Management Service checklist.

Recommendation 5. We recommended that Sterile Processing Service managers ensure quality control testing is performed on endoscopes that exceed a 12-day hang time and monitor compliance.

Concur

Target date for completion: 09/01/2017

Facility response: On May 12, 2017 an in-service was conducted for Endoscopy Staff. Endoscopy Registered Nurse began completing a daily checklist to ensure 100 percent of endoscopes stored in endoscope storage cabinets in the Gastrointestinal/Endoscopy Clinic would not exceed the 12-day hang time before the end of the next business day. Compliance with daily checklist will be reported monthly to the Sterile Processing Service Steering Committee until 100 percent compliance is obtained for three consecutive months.

Recommendation 6. We recommended that Sterile Processing Service managers ensure Sterile Processing Service employees receive training and competencies for the types of reusable medical equipment they reprocess.

Concur

Target date for completion: 07/01/2017

Facility response: Staff competencies were found to be misfiled. Supervisor did 100 percent review of competency folders and filed competencies in appropriate folders. This was completed April 2, 2017. Sterile Processing Service will create a master competency tracker by July 1, 2017 to ensure all staff have received training and competencies were completed for the reusable medical equipment each employee reprocesses. Competencies will be audited on a quarterly basis to ensure 95 percent compliance. Ongoing compliance will be reported quarterly to the Sterile Processing Service Steering Committee.

Recommendation 7. We recommended that facility managers ensure wall and ceiling holes and damage are repaired.

Concur

Target date for completion: 02/13/2017

Facility response: On February 13, 2017, Engineering repaired all holes in the walls and ceilings located in Sterile Processing Service. Ongoing compliance is monitored during Environment of Care rounds.

Recommendation 8. We recommended that facility managers ensure employees entering Sterile Processing Service areas wear the required personal protective equipment and monitor compliance.

Concur

Target date for completion: 09/01/2017

Facility response: On May 22, 2017 Sterile Processing Service employees were retrained on infection prevention requirements. Chief of Sterile Processing Service or designee will monitor personal protective equipment compliance on a daily basis. Compliance will be reported monthly to Sterile Processing Service Steering Committee until 90 percent compliance is obtained for three consecutive months. Ongoing compliance is monitored during Environment of Care rounds.

Recommendation 9. We recommended that facility managers ensure current standard operating procedures for reusable medical equipment are located in the area where reprocessing occurs.

Concur

Target date for completion: 09/01/2017

Facility response: Reprocessing only occurs in the Sterile Processing Service at Cooper and Optometry Clinic in Leestown. Books with current Standard Operating Procedures are present in both reprocessing areas. We re-validated their presence in the areas on June 23, 2017. The Chief of Sterile Processing Service or designee will monitor that current Standard Operating Procedures are present in the reprocessing areas monthly for 3 months and report compliance to the Sterile Processing Service Steering Committee.

Recommendation 10. We recommended that facility managers ensure the distance of items stored below a sprinkler deflector complies with Joint Commission standards and monitor compliance.

Concur

Target date for completion: 09/01/2017

Facility response: The item located within 18 inches of the sprinkler head was immediately removed. On May 22, 2017, Chief of Sterile Processing Service or designee began monitoring compliance on a daily basis. Compliance is being reported monthly to Sterile Processing Service Steering Committee until 90 percent compliance is obtained for three consecutive months. Ongoing compliance is monitored during Environment Care rounds.

Recommendation 11. We recommended that facility managers ensure all hemodialysis unit employees receive annual bloodborne pathogens training and monitor compliance.

Concur

Target date for completion: 09/01/2017

Facility response: The Talent Management System training records were reviewed for all hemodialysis unit employees. The employees without a current certificate were assigned and notified of the need to complete mandatory training by May 31, 2017. Training completion will be monitored and reported to Quality, Safety, and Value Council until 100 percent compliance for three consecutive months, then quarterly thereafter.

Recommendation 12. We recommended that the facility revise the anticoagulation management policy to include required baseline laboratory tests.

Concur

Target date for completion: 06/07/2017

Facility response: Anticoagulation policy was revised and approved on March 1, 2017 to include baseline laboratory tests. The updated policy was submitted to Public Affairs for publication on May 18, 2017.

Recommendation 13. We recommended that the facility review quality assurance data for the anticoagulation management program biannually and that facility managers monitor compliance.

Concur

Target date for completion: 03/01/2017

Facility response: Anticoagulation Program Quality Assurance data was reported on March 1, 2017 to Pharmacy and Therapeutics Committee. The Quality Assurance data will be reported on a biannual basis to Pharmacy and Therapeutic Committee and Health Care Delivery Council to ensure ongoing compliance.

Recommendation 14. We recommended that facility managers include nutrient interactions and drug to drug interactions associated with anticoagulation therapy in competency assessments for employees actively involved in the anticoagulant program and monitor compliance.

Concur

Target date for completion: 02/21/2017

Facility response: The anticoagulant program employees' competency assessment was updated to include nutrient interactions and drug-to-drug interactions associated with anticoagulation therapy. The competencies were completed on February 21, 2017. Competency folders are reviewed on an annual basis, thus ensuring ongoing compliance.

Recommendation 15. We recommended that facility managers ensure transfer notes written by acceptable designees document staff/attending physician approval and contain a staff/attending physician countersignature and monitor compliance.

Concur

Target date for completion: 07/01/2017

Facility response: On March 1, 2017, staff were educated on the need to ensure the referring provider is listed as a co-signer on the inter-facility transfer notes; referring

providers are to co-sign the note. Emergency Department Chief will audit documentation of all transfers. Compliance is reported monthly to Quality, Safety, and Value Council until 90 percent compliance is obtained for three consecutive months then quarterly monitoring by the transfer office will be reported to the Utilization Management Committee to ensure ongoing compliance.

Recommendation 16. We recommended that clinical employees discharge outpatients from the recovery area according to provider orders or criteria approved by moderate sedation clinical leaders and that clinical managers monitor compliance.

Concur

Target date for completion: 09/01/2017

Facility response: On February 28, 2017 an in-service was conducted for all Endoscopy staff, Dental Assistants, and Dental Sedation Providers, to ensure all patients are held until they meet discharge criteria. In endoscopy, 20 randomly selected endoscopy cases are monitored monthly to ensure compliance with discharge criteria. In dental, all cases are being reviewed by a dental provider monthly. Cases are being monitored until 95 percent compliance is obtained for three consecutive months. Compliance will be reported monthly to Quality, Safety, and Value Council.

Recommendation 17. We recommended that clinical managers ensure that clinical employees who perform or assist with moderate sedation have current training for the provision of moderate sedation care and that training is documented and monitor compliance.

Concur

Target date for completion: 09/01/2017

Facility response: Moderate sedation training records were reviewed to ensure 100 percent of clinical employees who perform or assist with moderate sedation are documented in Talent Management System. Medical Staff Services will ensure ongoing compliance by requiring providers to submit moderate sedation training certificates as part of the credentialing and re-credentialing process. On April 3, 2017, Nursing Service employees were reeducated on moderate sedation training requirements. A standardized process was implemented so current staff are required to complete training as part of their annual review process. Moderate sedation training compliance will be monitored quarterly, reported to appropriate Associate Director for Patient Care Services or Chief of Staff then reported to the Quality, Safety, and Value Council.

Recommendation 18. We recommended that facility managers ensure the Community Nursing Home Oversight Committee includes representation by all required disciplines.

Concur

Target date for completion: 06/05/2017

Facility response: Community Nursing Home was previously reporting to Extended Care Committee. On April 6, 2017, a new charter was developed for the Community Nursing Home Oversight Committee to include all disciplines required by directive. The Community Nursing Home Oversight Committee is scheduled to be held on June 5, 2017. The Community Nursing Home Oversight Committee will meet quarterly and report to the Extended Care Committee.

Recommendation 19. We recommended that the facility ensure integration of the community nursing home program into its quality improvement program.

Concur

Target date for completion: 09/01/2017

Facility response: On April 6, 2017 a new charter was developed for the Community Nursing Home Oversight Committee. The Community Nursing Home Oversight Committee Chair is reporting to the Community Nursing Home program quality improvement initiatives to the Extended Care Committee monthly. The Extended Care Delivery Council, which is chaired by the Chief of Staff, thus ensuring the Community Nursing Home program is integrated to the quality improvement program.

Recommendation 20. We recommended that facility managers ensure that registered nurses conduct and document cyclical clinical visits with the frequency required by Veterans Health Administration policy for community nursing home oversight and monitor compliance.

Concur

Target date for completion: 09/01/2017

Facility response: The allotment of Registered Nurse staff within the Community Nursing Home Program has been adjusted. The Community Nursing Home Program Coordinator will review both social work and nursing visits conducted and documented to ensure the frequencies meet the national directive. Monitoring will be done until 90 percent compliance is obtained for three consecutive months, then monitoring will change to quarterly. Monitoring will be reported to the Community Nursing Home Committee and Extended Care. The first report is scheduled for June 28, 2017.

Recommendation 21. We recommended that facility clinical managers ensure clinicians inform patients about the Patient Record Flags and the right to request to amend/appeal flag placement and monitor compliance.

Concur

Target date for completion: 09/01/2017

Facility response: All flagged Veterans were receiving notification letters by mail, on February 9, 2017 copies of notification letters began being electronically entered in to patient records under the Patient Record Flag Administrative Note. Notification letters contain amendment/appeal process and procedure. The Disruptive Behavior Committee Chair is monitoring the process and will report compliance to Healthcare Delivery Council monthly until 90 percent compliance is obtained for three consecutive months.

Recommendation 22. We recommended that facility managers ensure all employees receive Level 1 Prevention and Management of Disruptive Behavior training and additional training as required for their assigned risk area within 90 days of hire, ensure the training is documented in employee training records, and monitor compliance.

Concur

Target date for completion: 02/01/2018

Facility response: In March 2017, Learning Resource Center began assigning Level I Prevention and Management of Disruptive Behavior training at onset of employment. A Prevention and Management of Disruptive Behavior Coordinator will begin scheduling levels II, III, and IV Prevention and Management Disruptive Behavior training for all employees at onset of employment, based on their assigned risk area. The Prevention and Management Disruptive Behavior Coordinator will continuously monitor and report compliance monthly to Healthcare Delivery Council until 90 percent compliance is obtained for three consecutive months, then quarterly thereafter.

Recommendation 23. We recommended that Substance Abuse and Post-Traumatic Stress Disorder Residential Rehabilitation Treatment Program monthly self-inspections include assessment of privacy and that facility managers monitor compliance.

Concur

Target date for completion: 09/1/2017

Facility response: Mental Health Residential Rehabilitation Treatment Program Supervisors added privacy issues to the monthly self-inspection form. New self-inspection forms were implemented on March 1, 2017. Compliance will be reported monthly to Safety Committee until 90 percent compliance is obtained for six consecutive months.

Recommendation 24. We recommended that facility managers ensure locked mental health unit panic alarm testing includes VA Police response time and monitor compliance.

Concur

Target date for completion: 08/01/2017

Facility response: On February 21, 2017, a police time response component was added to the monthly alarm checklist. VA Police will record response times monthly. VA Police will monitor and report monthly to Environment of Care Committee until 90 percent compliance for three months, then quarterly thereafter.

OIG Contact and Staff Acknowledgments

Contact	For more information about this report, please contact OIG at (202) 461-4720.
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U.S. House of Representatives: Andy Barr, James Comer, S. Brett Guthrie, Thomas Massie, Harold Rogers, John A. Yarmuth

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

Endnotes

[a] The references used for QSV included:
- 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 EOC included:
- VA Handbook 6500, *Risk Management Framework for VA Information Systems – Tier 3: VA Information Security Program*, March 10, 2015.
- VHA Directive 1116(2), *Sterile Processing Services (SPS)*, March 23, 2016.
- VHA Directive 7704(1); *Location, Selection, Installation, Maintenance, and Testing of Emergency Eyewash and Shower Equipment*; February 16, 2016.
- Various requirements of The Joint Commission, Centers for Disease Control and Prevention, Occupational Safety and Health Administration, International Association of Healthcare Central Service Materiel Management, Health Insurance Portability and Accountability Act, National Fire Protection Association.

[c] The references used for Medication Management: Anticoagulation Therapy included:
- VHA Directive 1026; *VHA Enterprise Framework for Quality, Safety, and Value*; August 2, 2013.
- VHA Directive 1033, *Anticoagulation Therapy Management*, July 29, 2015.
- VHA Directive 1088, *Communicating Test Results to Providers and Patients*, October 7, 2015.

[d] The references used for Coordination of Care: Inter-Facility Transfers included:
- VHA Directive 2007-015, *Inter-Facility Transfer Policy*, May 7, 2007.
- VHA Handbook 1907.01, *Health Information Management and Health Records*, March 19, 2015.
- VHA Handbook 1400.01, *Resident Supervision*, December 19, 2012.

[e] The references used for Diagnostic Care: POCT included:
- VHA Handbook 1106.01, *Pathology and Laboratory Medicine Service Procedures*, October 6, 2008.
- VHA Handbook 1106.01, *Pathology and Laboratory Medicine Service (P&LMS) Procedures*, January 29, 2016.
- VHA Directive 1088, *Communicating Test Results to Providers and Patients*, October 7, 2015.
- The Joint Commission. *Comprehensive Accreditation Manual for Laboratories and Point-of-Care Testing*. Update 2. September 2010.
- Boaz M, Landau Z, Wainstein J. Analysis of Institutional Blood Glucose Surveillance. *Journal of Diabetes Science and Technology*. 2010;4(6):1,514–15. Accessed July 18, 2016.

[f] The references used for Moderate Sedation included:
- VHA Handbook 1004.01, *Informed Consent for Clinical Treatments and Procedures*, August 14, 2009.
- VHA Directive1039, *Ensuring Correct Surgery and Invasive Procedures*, July 26, 2013.
- VHA Directive 1073, *Moderate Sedation by Non-Anesthesia Providers*, December 30, 2014.
- VHA Directive 1177; *Cardiopulmonary Resuscitation, Basic Life Support, and Advanced Cardiac Life Support Training for Staff*; November 6, 2014.
- VA National Center for Patient Safety. *Facilitator's Guide for Moderate Sedation Toolkit for Non-Anesthesiologists*. March 29, 2011.
- American Society of Anesthesiologists. Practice Guidelines for Sedation and Analgesia by Non-Anesthesiologists. *Anesthesiology*. 2002; 96:1004–17.
- The Joint Commission. Hospital Standards. January 2016. PC.03.01.01, EP1 and MS.06.01.03 EP6.

[g] The references used for CNH Oversight included:
- VHA Handbook 1143.2, *VHA Community Nursing Home Oversight Procedures*, June 4, 2004.
- VA OIG report, *Healthcare Inspection – Evaluation of the Veterans Health Administration's Contact Community Nursing Home Program*, (Report No. 05-00266-39, December 13, 2007).

[h] The references used for Management of Disruptive/Violent Behavior included:

- VHA Directive 2012-026, *Sexual Assaults and Other Defined Public Safety Incidents in Veterans Health Administration (VHA) Facilities*, September 27, 2012.
- Public Law 112-154. Honoring America's Veterans and Caring for Camp Lejeune Families Act of 2012. August 6, 2012. 126 Stat. 1165. Sec. 106.
- Acting Deputy Under Secretary for Health for Operations and Management. "Meeting New Mandatory Safety Training Requirements using Veterans Health Administration's Prevention and Management of Disruptive Behavior (PMDB) Curriculum." memorandum. November 7, 2013.

[i] The references used for MH RRTP 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.

[j] The reference used for Panic Alarm Testing was:

- VA National Center for Patient Safety. "Mental Health EOC Checklist (MHEOCC)." December 8, 2016.

[k] The reference used for the Strategic Analytics for Improvement and Learning (SAIL) metric definitions was:

- VHA Support Service Center (VSSC), Strategic Analytics for Improvement and Learning (SAIL), accessed: October 3, 2016.

[l] The reference used for Patient Aligned Care Team Compass data graphs was:

- Department of Veterans' Affairs, Patient Aligned Care Teams Compass Data Definitions, accessed: December 19, 2016.