Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 08-00373-99

Combined Assessment Program Review of the VA Long Beach Healthcare System Long Beach, California

March 20, 2008

Washington, DC 20420

Why We Did This Review

Combined Assessment Program (CAP) reviews are part of the Office of Inspector General's (OIG's) efforts to ensure that high quality health care is provided to our Nation's veterans. CAP reviews combine the knowledge and skills of the OIG's Offices of Healthcare Inspections and Investigations to provide collaborative assessments of VA medical facilities on a cyclical basis. The purposes of CAP reviews are to:

- Evaluate how well VA facilities are accomplishing their missions of providing veterans convenient access to high quality medical services.
- Provide fraud and integrity awareness training to increase employee understanding of the potential for program fraud and the requirement to refer suspected criminal activity to the OIG.

In addition to this typical coverage, CAP reviews may examine issues or allegations referred by VA employees, patients, Members of Congress, or others.

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Executive Summary

Introduction

During the week of January 28–31, 2008, the OIG conducted a Combined Assessment Program (CAP) review of the VA Long Beach Healthcare System (VALBHS), Long Beach, CA. The purpose of the review was to evaluate selected operations, focusing on patient care administration and quality management (QM). During the review, we also provided fraud and integrity awareness training to 276 employees. The VALBHS is part of Veterans Integrated Service Network (VISN) 22.

Results of the Review

This CAP review covered eight operational activities. We also followed up on one review area from the prior CAP. We identified the following organizational strengths and reported accomplishments:

- Creative Patient Safety and Infection Prevention Fairs.
- Excellent Internal Monitoring of Blood Usage and Procedures.

We made recommendations in five of the activities reviewed. For these activities, the VALBHS needed to:

- Assure consistent data gathering, analysis, and reporting and document actions to address problems or trends.
- Monitor timeliness of peer reviews, root cause analyses (RCAs), and corrective action implementation and take appropriate interventions when timeframes are not met.
- Develop a mechanism to discuss all cases where review processes might identify adverse events so that the cases can be considered for disclosure and require documentation of full disclosure, as appropriate.
- Develop a plan for continuous performance review, including provider-specific QM/performance improvement (PI) results, and maintain provider profiles that demonstrate that the plans are being followed.
- Analyze patient complaints data organization-wide and report trends to appropriate venues that will take action, as needed.
- Develop and implement an effective process to ensure that environment of care (EOC) concerns identified by all

inspection teams are addressed and corrected in a timely manner.

- Ensure that fire drills are conducted in each patient care building and on all shifts, as required.
- Require that weekly controlled substances (CS) inventory checks be performed in all required areas, including the bronchoscopy suite.
- Ensure that nurses consistently document the effectiveness of all pain medications within the required timeframe.
- Ensure that all business rules are in compliance with VHA guidance.

The VALBHS complied with selected standards in the following three activities:

- Emergency Department (ED) Operations.
- Patient Satisfaction Survey Scores.
- Staffing.

This report was prepared under the direction of Julie Watrous, Director, Los Angeles Office of Healthcare Inspections.

Comments

The VISN and VALBHS Directors concurred with the findings and recommendations and submitted acceptable improvement plans. (See Appendixes A and B, pages 16–22, for the full text of the Directors' comments.) We will follow up on the planned actions until they are completed.

(original signed by:)
JOHN D. DAIGH, JR., M.D.
Assistant Inspector General for
Healthcare Inspections

Introduction

Profile

Organization. The VALBHS is a tertiary facility located in Long Beach, CA, that provides a broad range of inpatient and outpatient health care services. Outpatient care is also provided at four community based outpatient clinics in Santa Ana, Santa Fe Springs, Long Beach, and Anaheim, CA. The VALBHS is part of VISN 22 and serves a veteran population of about 200,000 throughout Orange County and parts of Los Angeles County.

Programs. The VALBHS provides medical, surgical, behavioral, geriatric, spinal cord injury/disorders, and rehabilitation services. It has 313 hospital and 110 nursing home beds.

Affiliations and Research. The VALBHS is affiliated with several institutions, including the University of California's Irvine School of Medicine and California State University, Long Beach, and provides training for 150 residents and medical students and for health trainees in various disciplines. In fiscal year (FY) 2007, the VALBHS research program had 158 projects and a budget of $6 million. Important areas of research included bone regeneration, estrogen receptors, and magnetic stimulation for spinal cord injury patients.

Resources. In FY 2007, the medical care budget was approximately $285.5 million. FY 2007 staffing was 1,904 full-time employee equivalents (FTE), including 122.7 physician and 613.7 nursing FTE.

Workload. In FY 2007, the VALBHS treated 41,338 unique patients. The inpatient care workload totaled 5,793 discharges, and the average daily census, including nursing home patients, was 212. Outpatient workload totaled 469,131 visits.

Objectives and Scope

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

- Conduct recurring evaluations of selected health care facility operations, focusing on patient care administration and QM.

- Provide fraud and integrity awareness training to increase employee understanding of the potential for program fraud and the requirement to refer suspected criminal activity to the OIG.

Scope. We reviewed selected clinical and administrative activities to evaluate the effectiveness of patient care administration and QM. Patient care administration is the process of planning and delivering patient care. QM is the process of monitoring the quality of care to identify and correct harmful and potentially harmful practices and conditions.

In performing the review, we inspected work areas; interviewed managers and employees; and reviewed clinical and administrative records. The review covered the following eight activities:

- Business Rules for Veterans Health Information Systems.
- ED Operations.
- EOC.
- Medication Management.
- Patient Satisfaction Survey Scores.
- Pharmacy Operations and CS Inspections.
- QM.
- Staffing.

The review covered VALBHS operations for FY 2007 and FY 2008 through January 28, 2008, and was done in accordance with OIG standard operating procedures for CAP reviews.

We also followed up on selected recommendations from our prior CAP review of the VALBHS (*Combined Assessment Program Review of the VA Long Beach Healthcare System, Long Beach, CA,* Report No. 04-02815-88, March 3, 2005). We had identified an improvement opportunity in the contract community nursing home program. During our follow-up review, we found sufficient evidence that program managers and staff provided appropriate oversight of the patients in the program and that patients received the required monthly visits. We consider this issue closed.

During this review, we also presented fraud and integrity awareness briefings for 276 employees. These briefings covered procedures for reporting suspected criminal activity to the OIG and included case-specific examples illustrating procurement fraud, conflicts of interest, and bribery.

In this report, we make recommendations for improvement. Recommendations pertain to issues that are significant enough to be monitored by the OIG until corrective actions are implemented. The activities in the "Review Activities Without Recommendations" section have no reportable findings.

Organizational Strengths and Reported Accomplishments

Creative Patient Safety and Infection Prevention Fairs

In 2007, the Patient Safety Manager and the Infection Control (IC) Manager collaborated to provide educational materials in new ways during designated patient safety and infection prevention weeks. In March, the theme for patient safety week was "Patient Safety – A Road Taken Together." Each individual attending the event was given a road map to navigate and earned stamps after learning about important issues, such as fall prevention and patient safety goals. All participants who completed the course received free lunches. More than 550 staff, patients, and volunteers participated in the event.

In October, infection prevention week focused on hand hygiene. The IC Manager, the Patient Safety Manager, and the Safety Office Manager provided education, and staff, including executive management, signed large posters located throughout the facility to show their commitment to hand hygiene. Also, education about the importance of flu shots was provided to over 300 staff members and patients, and more than 150 people received flu shots.

Excellent Internal Monitoring of Blood Usage and Procedures

The VALBHS had a strong, systematic review process to monitor the use of blood products and the performance of procedures throughout the facility. The review process included overall parameters and a close review of outliers, as well as efforts to improve performance. For example, the close scrutiny of all blood products usage resulted in a steady reduction in all types of products used from a high of over 7,000 units in 1993 to approximately 4,000 units in 2006. Improvement actions in the blood usage review area

included blood type and Rhesus factor verification on second samples for all new patients, a new procedure for tissue procurement, and a program for new resident orientation to the blood bank.

Regarding procedures review, all sections performing procedures routinely reported on total numbers, complications, and any trends. Actions to improve documentation included the creation and implementation of new template progress notes for moderate sedation and pre-operative assessment.

Results

Review Activities With Recommendations

Quality Management

The purpose of this review was to evaluate whether the VALBHS's QM program provided comprehensive oversight of the quality of care and whether senior managers actively supported the program's activities. We interviewed the VALBHS Director, Chief of Staff, Chief Nurse Executive, and Chief of QM. We also interviewed QM personnel and several other service chiefs. We evaluated plans, policies, and other relevant documents.

The QM program was generally effective in providing oversight of the VALBHS's quality of care. Appropriate review structures were in place for 10 of the 15 program activities reviewed. However, we identified five areas that needed improvement.

Data Gathering, Analysis, and Reporting. Data gathering, analysis, and reporting are required in many QM and PI areas. Although we found evidence of data gathering in many required areas, gaps were noted in some areas where key positions had been reassigned or were vacant. Also, improvement was needed in documenting discussions about data analyses that were presented in committee and council meetings.

For example, although restraint data were gathered, there was no evidence that data were analyzed between January and November 2007. Once a staff person was assigned to analyze the data, analyses for the entire period were completed. Also, the FY 2007 mortality analysis identified trends that merited explanation. However, we did not find that these trends were discussed in either the report or the

meeting minutes. We were told that a detailed discussion took place at the meeting but was not documented in the minutes.

Managers agreed that key QM/PI data elements needed to be defined, primary and back-up staff responsibilities needed to be assigned, and detailed discussions of data trends needed to take place and be appropriately documented.

Recommendation 1 We recommended that the VISN Director ensure that the VALBHS Director requires that service chiefs, program coordinators, and committee chairpersons assure consistent data gathering, analysis, and reporting; document discussions about data analyses; and document actions to address problems or trends.

The VISN and VALBHS Directors concurred with the findings and recommendation. Education was provided to the committees and councils. A data collection plan was developed that included a new collection tool to assure consistent reporting. The corrective actions are acceptable, and we consider this recommendation closed.

Timeliness of Review Processes. VHA requires that clinicians review serious adverse events and take actions to correct identified problems. For FY 2007, required timeframes for both peer reviews and RCAs were not met. For example, VHA requires RCAs to be completed within 45 days, yet the FY 2007 average was 83.8 days. In addition, corrective action plans from RCAs had not been fully implemented in reasonable timeframes.

It is important to timely complete both peer reviews and RCAs so that issues can be quickly identified and addressed and so that similar incidents can be prevented. Managers told us that the delays were partially caused by staff vacancies. Timeliness of reviews and action item implementation needed to be a higher priority for all VALBHS managers.

Recommendation 2 We recommended that the VISN Director ensure that the VALBHS Director requires that peer review and RCA timeliness and corrective action implementation are monitored and that appropriate interventions are taken when required timeframes are not met.

The VISN and VALBHS Directors concurred with the findings and recommendation. Peer reviews will be assigned within 24 hours, and providers will be held to due dates. RCA teams will be assigned upon discovery of the event, teams will be held to due dates, and action items will be monitored to ensure that implementation is timely. The improvement plan is acceptable, and we will follow up on the completion of the planned actions.

Adverse Event Disclosure Process. When serious adverse events occur as a result of patient care, VHA policy requires that staff discuss the events with the patients and, with input from VA Regional Counsel, inform them of their right to file tort or benefits claims. During the period January 2007–January 2008, we identified at least five cases of adverse events that had not been considered for disclosure. VALBHS managers need to determine a mechanism to discuss all cases where review processes might identify adverse events so that cases can be considered for disclosure.

Recommendation 3 We recommended that the VISN Director ensure that the VALBHS Director requires that appropriate managers develop a mechanism to discuss all cases where review processes might identify adverse events so cases can be considered for disclosure and that full disclosure is documented, as appropriate.

The VISN and VALBHS Directors concurred with the findings and recommendation. Cases reviewed in several defined venues will be discussed by the Patient Safety/Risk Management Advisory Group. Decisions will be made regarding further review and disclosure. The improvement plan is acceptable, and we will follow up on the completion of the planned actions.

Provider Profiles. As of January 1, 2007, accreditation standards require that clinical managers continuously review performance, including QM and PI results, for all privileged providers. We did not find any evidence that clinical service chiefs had developed plans that define the provider-specific QM/PI results that will be reviewed or the frequency of review.

Recommendation 4 We recommended that the VISN Director ensure that the VALBHS Director requires clinical service chiefs to develop

plans for continuous performance review, including provider-specific QM/PI results, and maintain provider profiles that demonstrate that the plans are being followed.

The VISN and VALBHS Directors concurred with the findings and recommendation. All privileged providers will complete a specified number of reviews of other providers' care. Reviews now include a wider variety of criteria, including criteria specific to each health care group (HCG). The improvement plan is acceptable, and we will follow up on the completion of the planned actions.

Patient Complaints Analyses. Patient advocates received patient complaints and addressed individual complaints. They shared the results with product line chiefs. However, we did not find evidence that organization-wide complaints data were thoroughly analyzed, that trends were identified, or that recommendations for corrective action were made. VALBHS managers need to determine how organization-wide information will be reported and which committee or council should be responsible for acting upon the recommendations. This was also a finding in the previous CAP review.

Recommendation 5 We recommended that the VISN Director ensure that the VALBHS Director requires full analysis of patient complaints data with trend reporting to appropriate venues that will take action, as needed.

The VISN and VALBHS Directors concurred with the findings and recommendation. Patient complaints will be fully analyzed at the HCG and organization-wide levels. Action plans will be required for all identified issues. The improvement plan is acceptable, and we will follow up on the completion of the planned actions.

Environment of Care

The purpose of this review was to determine if the VALBHS complied with selected IC standards and maintained a safe and clean patient care environment. VHA facilities are required to establish a comprehensive EOC program that meets VHA National Center for Patient Safety, Occupational Safety and Health Administration, and Joint Commission standards.

We evaluated the IC program to determine compliance with VHA directives. IC staff appropriately collected, trended, and

analyzed data related to infections, and they involved clinicians in improvement initiatives to reduce infection risks for patients and staff.

We conducted onsite inspections of outpatient care areas (primary and specialty care clinics), the ED, inpatient medical-surgical units (S4, S8, S10, N4, V1, and V2), the intensive care unit (ICU), procedure suites (dialysis, infusion, radiology, and gastrointestinal), nursing home care units (X and Z Pods), and locked inpatient mental health units (L1 and M1).

On Unit L1, managers had appropriately evaluated and addressed safety issues, as required. However, of the 36 staff required to undergo initial training to identify environmental hazards, 10 did not receive this training until we arrived onsite on January 28, 2008. Program managers assured us that annual training would be completed for all appropriate staff in a timely manner. Therefore, we did not make a recommendation in this area.

Overall, we found the areas we inspected to be generally clean. However, we identified conditions that required managers' attention, such as patient refrigerators containing unidentified and outdated nourishments, expired medications and supplies, cluttered and unclean utility rooms and housekeeping closets, unused equipment that needed to be turned in, and patient rooms that needed additional cleaning. We also identified general maintenance issues related to minor painting, baseboard replacement, and bathroom caulking. Managers took immediate actions to correct most of the deficiencies we identified. However, two issues needed to have corrective actions implemented.

Environment of Care Inspections Follow-Up Actions. Our review of VALBHS and VISN inspection reports revealed that most of our findings had already been identified. The Safety Program Manager acknowledged that VALBHS did not have an efficient process to ensure that deficiencies were followed up and addressed in a timely manner. Program managers told us that they were in the process of evaluating several software programs that would facilitate tracking of EOC issues from initial identification until resolution. Until managers are assured of the effectiveness of tracking and follow-up processes, each HCG chief needs to be more

vigilant in monitoring his or her areas of responsibility to ensure a clean and safe patient care environment.

Recommendation 6 We recommended that the VISN Director ensure that the VALBHS Director requires program managers to develop and implement an effective process to ensure that EOC concerns identified by all inspection teams are addressed and corrected in a timely manner.

The VISN and VALBHS Directors concurred with the findings and recommendation. Inspections are ongoing to assure compliance with identified findings. Monthly reports will be submitted to senior management regarding outstanding deficiencies, and action plans will be expected. Software is under consideration to assist with tracking deficiencies. The improvement plan is acceptable, and we will follow up on the completion of the planned actions.

Fire Drills. Accreditation standards and local policy require facilities to conduct regular fire drills on all shifts in each patient care building to achieve a fire-safe environment. We found that for 3 quarters (April 1–December 31, 2007), fire drills were not consistently conducted on all shifts in all patient care buildings.

Recommendation 7 We recommended that the VISN Director ensure that the VALBHS Director requires that fire drills are conducted in each patient care building and on all shifts, as required.

The VISN and VALBHS Directors concurred with the findings and recommendation. An annual fire drill schedule that includes all required areas of the facility was developed. Actual drills will be monitored monthly, and reports will be submitted to senior management quarterly. The improvement plan is acceptable, and we will follow up on the completion of the planned actions.

Pharmacy Operations and Controlled Substances Inspections

The purpose of this review was to evaluate whether VHA facilities had adequate controls to ensure pharmacy security and proper CS management. We also assessed whether clinical managers had processes in place to monitor polypharmacy (patients prescribed multiple medications), especially in vulnerable populations.

The inpatient and outpatient pharmacies' internal environments were clean and well maintained. The local

annual security inspection had identified a deficiency in the outpatient pharmacy. Pharmacy dispensing windows are required to be set in a wall that contains a minimum of 4 inches of solid concrete masonry. These windows had the required ballistic protection, but the walls around the windows did not. During our review, managers provided an acceptable interim measure to address this deficiency.

The VALBHS had appropriate procedures to ensure that clinical pharmacists identified patients who were receiving multiple prescription medications, reviewed their medication regimens to avoid polypharmacy, and appropriately advised providers.

Overall, the CS inspection program was well organized. Monthly unannounced pharmacy inspections were conducted, as required, and the CS Coordinator and inspectors had received appropriate training to execute their duties. However, we identified one area that needed improvement.

Weekly Inventory Checks. We found that required weekly CS inventory checks in the bronchoscopy suite had not been performed for more than 12 months. Managers acknowledged this infraction and indicated that a planned reorganization of all procedure areas will address this deficiency.

Recommendation 8 We recommended that the VISN Director ensure that the VALBHS Director requires that weekly CS inventory checks be performed in all required areas, including the bronchoscopy suite.

The VISN and VALBHS Directors concurred with the finding and recommendation. Assignments were made for the weekly inventory checks in the bronchoscopy suite, and checks have been performed since January 17, 2008. The improvement plan is acceptable, and we will follow up on the completion of the planned actions.

Medication Management

The purpose of this review was to evaluate whether VHA facilities had adequate medication management practices. A safe medication management system includes medication ordering, administering, and monitoring. We reviewed medication management processes in the ED and in selected acute inpatient and nursing home care units. Generally, we found adequate management of medications brought into the

facility by patients or their families and appropriate use of patient armbands to correctly identify patients prior to medication administration. We found one area that needed improvement.

Pain Medication Effectiveness. Nurses did not consistently document the effectiveness of pain medications in accordance with VALBHS policy and accreditation standards. We reviewed the Bar Code Medication Administration records for 15 patients who were hospitalized either on an acute medical-surgical unit or a locked mental health unit at the time of our visit. For each patient, we reviewed documentation for several doses of pain medication. The effectiveness of pain medication was not documented in 13 of the 44 total doses reviewed (30 percent). In 17 of the remaining 31 doses (55 percent), effectiveness was not documented within 90 minutes, as required by policy. Without appropriate follow-up and documentation, clinicians could not be assured that patients' pain was effectively managed.

Recommendation 9 We recommended that the VISN Director ensure that the VALBHS Director requires that nurses consistently document the effectiveness of all pain medications within the required timeframe.

The VISN and VALBHS Directors concurred with the findings and recommendation. Nurses will run a report after medication administration and at shift change to check that pain medication effectiveness was addressed and documented. Nurse managers will monitor compliance. The improvement plan is acceptable, and we will follow up on the completion of the planned actions.

Business Rules for Veterans Health Information Systems

The purpose of this review was to determine whether business rules governing the patient health record (electronic and paper) complied with VHA policy. The health record includes entries, such as physician orders, progress notes, and test reports. Once entries are signed, they must be maintained in unaltered form. New information or corrections may be added to the record as addenda to the original notes or as new notes. Business rules define what functions certain groups or individuals are allowed to perform in the health record.

In October 2004, VHA's Office of Information (OI) provided guidance that advised VHA facility managers to review their business rules and delete any rules that allowed editing of signed medical records. The OI also recommended that the ability to edit signed records be limited to a facility's Privacy Officer. On June 7, 2006, VHA instructed all facilities to comply with the OI guidance.

We reviewed VHA and local policies and examined more than 350 business rules. The VALBHS had a written procedure for correcting erroneous patient information. However, we identified three business rules that allowed individuals other than the Chief of the Health Information Management Service or the Privacy Officer to amend signed documents. In addition, the local policy did not delineate individuals authorized to change note titles or reassign documents. While we were onsite, program managers provided an updated policy.

Recommendation 10 We recommended that the VISN Director ensure that the VALBHS Director requires program managers to delete erroneous rules and conduct periodic reviews of all business rules to ensure compliance with VHA requirements.

The VISN and VALBHS Directors concurred with the findings and recommendation. The policy was updated, a software patch was installed, and a monitoring process was implemented. The corrective actions are acceptable, and we consider this recommendation closed.

Review Activities Without Recommendations

Staffing

The purpose of this review was to evaluate whether VHA facilities have developed comprehensive staffing guidelines and whether the guidelines have been met. We found that the VALBHS had developed staffing guidelines for nurse staffing, and we found them to be adequate. We reviewed actual staffing for the ED and for selected acute inpatient and nursing home care units. We found that guidelines for nurse staffing were generally met and that specific actions had been taken to ensure safe patient care, including cross-coverage and use of registry nurses. Therefore, we made no recommendations.

Emergency Department Operations

The purpose of this review was to evaluate whether VHA facility EDs complied with VHA guidelines related to hours of operation, clinical capability, staffing adequacy, and staff competency. In addition, we inspected the VALBHS ED environment for cleanliness and safety.

The ED is open 24 hours per day, 7 days per week, as required for an ED. The ED is located within the main hospital building, and the emergency services provided are within the facility's capability. In addition, the VALBHS has an appropriate policy for managing patients whose care may exceed the facility's capability.

We reviewed the ED nurse staffing plan and time schedules and determined that managers had consistently followed their established staffing guideline for allocating nursing resources. We also found that managers had appropriately documented demonstrated nursing competencies.

We found a room identified as a seclusion room that did not meet all safety standards. ED staff told us that this room had not been used for seclusion for several years and that any patients who require close monitoring are either assigned a dedicated staff member for one-to-one observation or placed in close proximity to the nurse's station. While we were onsite, managers placed a sign that clearly identified this room as a storage area. Therefore, we did not make a recommendation.

Patient Satisfaction Survey Scores

The purpose of this review was to assess the extent that VHA medical centers use the quarterly survey results of patients' health care experiences with VHA to improve patient care services. VHA set performance measure results for patients reporting overall satisfaction of "very good" or "excellent" at 76 percent for inpatients and 77 percents for outpatients.

Figures 1 and 2 on the next page show the VALBHS's patient satisfaction performance measure results for inpatients and outpatients, respectively.

Figure 1:

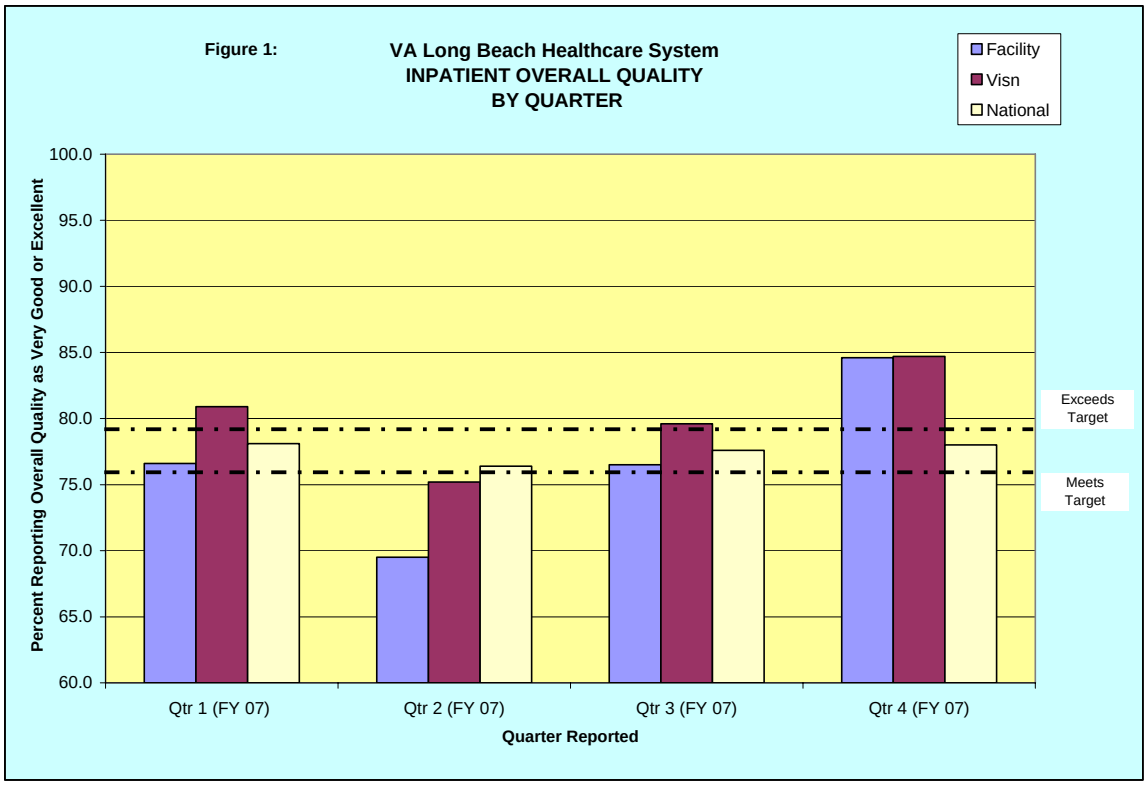
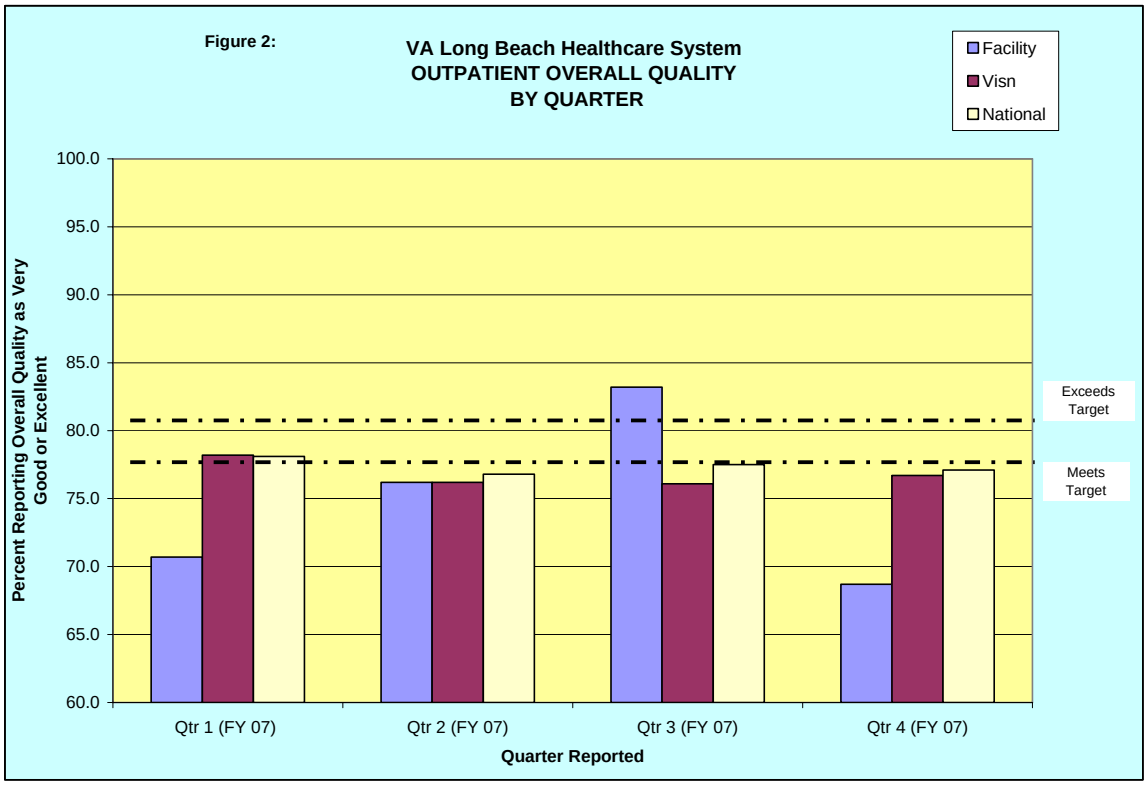


Figure 2:



The VALBHS's inpatient scores met or exceeded the target in 3 of 4 quarters in FY 2007. Outpatient scores met the target in 1 of 4 quarters in FY 2007. Managers had implemented action plans to improve satisfaction with outpatient care. We found the action plans acceptable and made no recommendations.

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: March 10, 2008

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

Subject: Combined Assessment Program Review of the VA Long Beach Healthcare System, Long Beach, California

To: Director, Los Angeles Healthcare Inspections Division (54LA)

Director, Management Review Service (10B5)

1. Thank you for your draft report of the CAP Review, which was conducted at the VA Long Beach Healthcare System January 28–31, 2008. I have reviewed your findings and recommendations and concur with the responses and corrective actions provided in this report.

2. I would like to take this opportunity to applaud the CAP team for conducting an effective, careful, and comprehensive survey. We very much appreciate the professional manner in which the survey was conducted and the interactions that occurred between the surveyors and facility staff.

3. Should you have questions regarding our response, please contact Linda Swan, RN, Network 22 Patient Safety Officer/Acting Quality Management Officer at (562) 826-5963.

(original signed by:)

William C. Raymer for:

John B. Bright

Attachment

Healthcare System Director Comments

Comments to Office of Inspector General's Report

The following Director's comments are submitted in response to the recommendations in the Office of Inspector General report:

OIG Recommendations

Recommendation 1. We recommended that the VISN Director ensure that the VALBHS Director requires that service chiefs, program coordinators, and committee chairpersons assure consistent data gathering, analysis, and reporting; document discussions about data analyses; and document actions to address problems or trends.

Concur

Target Date of Completion/Implementation: February 27, 2008

Planned Action:

In February 2008, education on reporting responsibilities was issued to committees and councils. A data collection plan was issued with an approved collection tool to assure consistent data gathering, analysis, and reporting to parent councils and committees. The approved tool will be submitted to the council or committee prior to the verbal report being given and will be embedded in the minutes of the meeting.

To ensure accurate documentation of discussions, a member of the senior leadership team has been assigned to work with the council's support staff on accurately capturing the discussions occurring during a council or committee meeting.

Recommendation 2. We recommended that the VISN Director ensure that the VALBHS Director requires that peer review and RCA timeliness and corrective action implementation are monitored and that appropriate interventions are taken when required timeframes are not met.

Concur

Target Date of Completion/Implementation: February 1, 2008

Planned Actions:

The peer review process was analyzed, and two areas of concern were identified:

- Effective 2/1/08, assignment of all peer reviews will occur within 24 hours of request by the chief of the service and/or his designee.

- Effective 2/1/08, the Risk Manager will send a reminder notice to the provider on day 30, reminding the provider of the absolute due date.

The RCA process was analyzed, and three areas of concern were identified:

- Effective 2/1/08, assignment of all RCA's will occur immediately upon discovery of event.

- Effective 2/1/08, the Patient Safety Manager will meet with all RCA teams to emphasize the deadline date. Reminders will be sent to the team leader on day 30 of the process.

- Previously all RCA's were chaired by the Patient Safety Manager; effective 11/1/07, all RCA teams will have the new PI facilitator assigned to the group to keep the group on task and timely.

All action items (100 percent) will be closed in SPOT software through the National Center for Patient Safety to monitor that corrective action items are implemented in a timely fashion.

Recommendation 3. We recommended that the VISN Director ensure that the VALBHS Director requires that appropriate managers develop a mechanism to discuss all cases where review processes might identify adverse events so cases can be considered for disclosure and that full disclosure is documented, as appropriate.

Concur

Target Date of Completion/Implementation: March 1, 2008

Planned Action:

All Health Care Groups (HCG) are to submit the worksheet developed by the Quality Manager monthly which identifies all cases reviewed during episode of care chart reviews, Mortality and Morbidity reviews, NSQIP reviews, and infection control reviews. All adverse events will be reviewed by the Patient Safety/Risk Management Advisory group with a disposition decided on all cases (RCA, Peer Review, and/or full disclosure). All level 3 cases will be considered for Institutional disclosure, all level 2 cases will be considered for Institutional/Clinical disclosure, and level 1 cases will be reviewed to determine if full disclosure is warranted.

Recommendation 4. We recommended that the VISN Director ensure that the VALBHS Director requires clinical service chiefs to develop plans for continuous performance review, including provider-specific QM/PI results, and maintain provider profiles that demonstrate that the plans are being followed.

Concur

Target Date of Completion/Implementation: March 1, 2008

Planned Action:

The peer review form was revised, and title was changed to read "Credentialing Peer Review" form. Other monitors were added to the form, which include at a minimum Medication Reconciliation, complete and accurate problem list, clinical reminders addressed and updated, and compliance with cut and paste policy. Specific monitors will be added by the HCG and communicated to the provider at the beginning of the credentialing period. A minimum of 12 reviews on every provider will be required for every credentialing period (2 years). Spreadsheets were distributed to the HCG Chiefs to assist in coordinating which physician will be reviewed and by whom to keep track of due dates.

Recommendation 5. We recommended that the VISN Director ensure that the VALBHS Director requires full analysis of patient complaints data with trend reporting to appropriate venues that will take action as needed.

Concur

Target Date of Completion/Implementation: March 1, 2008

Planned Action:

The Patient Advocate Tracking System (PATS) monthly reports are distributed to each HCG Chief and the Business Manager, in addition to the Service and Workforce Excellence Committee (SWEC), for monthly review.

If there are issues identified within the HCG on the monthly PATS report, an action plan for improvement will be submitted to the SWEC within 15 days.

A quarterly PATS report will be submitted to the Executive Leadership Board (ELB) addressing a total of all concerns involving the Customer Service Standards, current trends in patient complaints, and proposed action plans for improvement.

Recommendation 6. We recommended that the VISN Director ensure that the VALBHS Director requires program managers to develop and implement an effective process to ensure that EOC concerns identified by all inspection teams are addressed and corrected in a timely manner.

Concur

Target Date of Completion/Implementation: March 1, 2008

Planned Actions:

Effective 3/1/08, the Safety Manager is utilizing a volunteer (with previous safety experience) to physically visit the inspection sites to assure compliance in the closure of deficiencies.

The medical center is investigating a software program to facilitate the documentation, tracking, closure, and trending of EOC deficiencies. The report will be submitted to the Environment of Care Council (ECC), proposing the use of the software program, at the April 2008 meeting.

Monthly reports will be submitted to the ECC and ELB on the number of outstanding deficiencies remaining after the 14-day closure day. All HCG chiefs with outstanding user deficiencies to submit an action plan to the ECC for closure of outstanding deficiencies.

Recommendation 7. We recommended that the VISN Director ensure that the VALBHS Director requires that fire drills are conducted in each patient care building and on all shifts, as required.

Concur

Target Date of Completion/Implementation: February 1, 2008

Planned Action

The Safety Manager created a yearly schedule to encompass all areas of the medical center which require drills. Additional spreadsheets to document the fire drills – by building, specific location, date, and shift have been put adopted by the Safety Department.

Safety staff members who conduct the drills are required to provide the Safety Manager with documentation within 48 hours of each drill.

Data will be provided to the ECC on a quarterly basis for all fire drills (healthcare and business/ambulatory occupancy).

Recommendation 8. We recommended that the VISN Director ensure that the VALBHS Director requires that weekly CS inventory checks be performed in all required areas, including the bronchoscopy suite.

Concur

Target Date of Completion/Implementation: January 17, 2008

Planned Action:

One area was identified as non-compliant with CS weekly inventory checks. As of 1/17/08, a Pharmacist and an RN were assigned to do the weekly inventory in the bronchoscopy suite. Since this date, the monthly narcotics inspection reports have consistently shown all weekly inventories have been done and documented, as required, in the bronchoscopy suite.

Recommendation 9. We recommended that the VISN Director ensure that the VALBHS Director requires that nurses consistently document the effectiveness of all pain medications within the required timeframe.

Concur

Target Date of Completion/Implementation: March 1, 2008

Planned Action

Licensed staff nurses run a "PRN Effective List" at the beginning of the shift, after each major medication pass, and at the end of each shift and document PRN effectiveness. Additionally, Nurse Managers will monitor employee compliance with documentation of PRN effectiveness. Nurse Managers and Patient Care Services Chiefs will report compliance monthly at the Nurse Executive Council (NEC) meeting.

Recommendation 10. We recommended that the VISN Director ensure that the VALBHS Director requires program managers to delete erroneous rules and conduct periodic reviews of all business rules to ensure compliance with VHA requirements.

Concur

Target Date of Completion/Implementation: Business rules completed 2/7/08, Final policy approval 3/4/08

Planned Action

While the IG was on station, the Health System Policy (HSP) 04-28 was updated to include CPRS business rules. Updates to the policy were

accepted by the site visit team, and the HSP went for final approval to the CPRS Committee on 3/4/08.

On 2/7/08, a TIU patch *1*234 was installed. This patch overrides business rules that have in the past allowed the editing of unsigned documents by others than the Chief HIMS or Privacy Officer. Annual review of CPRS Business Rules will continue to be monitored by the CPRS Committee.

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