Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 08-02413-34

Combined Assessment Program Review of the Cheyenne VA Medical Center Cheyenne, Wyoming

December 3, 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.

Table of Contents

Executive Summary

Introduction

During the week of September 29–October 3, 2008, the OIG conducted a Combined Assessment Program (CAP) review of the Cheyenne VA Medical Center (the medical center), Cheyenne, WY. 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 67 medical center employees. The medical center is part of Veterans Integrated Service Network (VISN) 19.

Results of the Review

The CAP review covered nine operational activities. We identified the following organizational strength and reported accomplishment:

- Fall Reduction Program.

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

- Consistently trend, analyze, and routinely report QM data to the appropriate oversight committee and document discussion, actions, and follow-up in committee minutes.
- Communicate and document disclosure of adverse events.
- Check emergency carts, as required by local policy.
- Monitor and document temperatures of medication refrigerators.
- Consistently collect hand hygiene compliance data in accordance with local policy.
- Complete discharge documentation, as required by local policy.
- Complete emergency department/urgent care clinic (ED/UCC) inter-facility transfer documentation, as required by Veterans Health Administration (VHA) and local policy.
- Appoint a non-clinical Controlled Substances Coordinator (CSC).
- Ensure that the medical center's Director signs appointment letters for controlled substances inspectors.
- Repair the pharmacy vault day gate.
- Monitor temperatures and document required temperature checks for the pharmacy refrigerators.

The medical center complied with selected standards in the following four activities:

- Medication Management.
- Physician Privileges.
- Staffing.
- Survey of Healthcare Experiences of Patients (SHEP).

This report was prepared under the direction of Virginia L. Solana, Director, and Dorothy Duncan, Associate Director, Kansas City Office of Healthcare Inspections.

Comments

The VISN and Medical Center Directors agreed with the CAP review findings and recommendations. (See Appendixes A and B, pages 17–21, 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 medical center is located in Cheyenne, WY, and provides a broad range of inpatient and outpatient health care services. Outpatient care is also provided at three community based outpatient clinics (CBOCs) in Fort Collins and Greeley, CO, and in Sidney, NE. The medical center is part of VISN 19 and serves a veteran population of about 69,000 throughout southern Wyoming, northeastern Colorado, and southwestern Nebraska.

Programs. The medical center provides primary and secondary inpatient services in medicine and surgery and outpatient services in medicine, surgery, and psychiatry. It also provides 24-hour urgent care services. The medical center has 21 hospital beds and 50 community living center (CLC) beds.[1]

Affiliations. The medical center is affiliated with the University of Wyoming Family Medicine Residency Program at Cheyenne. This affiliation provides four funded resident positions. An affiliation has also been developed with the University of Colorado Denver's School of Medicine. The medical center does not have a research mission.

Resources. In fiscal year (FY) 2007, medical care expenditures totaled $68.9 million. The FY 2008 medical care budget was $71.8 million. FY 2007 staffing was 416 full-time employee equivalents (FTE), including 25 physician and 117 nursing FTE.

Workload. In FY 2007, the medical center treated 16,023 unique patients and provided 5,205 inpatient days in the hospital and 13,485 inpatient days in the CLC. The inpatient care workload totaled 1,081 discharges. The average daily census was 14 for the hospital and 37 for the CLC. Outpatient workload totaled 147,488 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:

[1] A CLC (formerly called a nursing home care unit) provides compassionate, person-centered care in a safe and homelike environment to eligible veterans who require a nursing home level of care.

- 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 nine activities:

- Coordination of Care.
- ED/UCC.
- Environment of Care (EOC).
- Medication Management.
- Pharmacy Operations.
- Physician Privileges.
- QM.
- SHEP.
- Staffing.

The review covered medical center operations for FY 2007 and FY 2008 through August 31, 2008, and was done in accordance with OIG standard operating procedures for CAP reviews. We also followed up on select recommendations from our prior CAP review of the medical center (*Combined Assessment Program Review of the Cheyenne VA Medical Center, Cheyenne, Wyoming,* Report No. 06-01519-78, February 6, 2007). The medical center had corrected all but two health care related findings from our prior CAP review. Those findings are discussed in the QM section of this report.

During this review, we also presented fraud and integrity awareness briefings for 67 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. Activities in the "Review Activities Without Recommendations" section have no reportable findings.

Organizational Strength

Fall Reduction Program

In 2004, an interdisciplinary team from the medical center developed a goal of creating an evidence-based fall prevention program. The purpose of the innovation was to change work practices and the physical environment to improve patient and employee safety. Actions included adopting the Morse Fall Scale to assess the fall risk of patients, incorporating this scale into the nursing admission assessment, standardizing fall prevention interventions, optimizing the use of tools and equipment, and developing and implementing effective data collection tools. A significant outcome that has resulted from this program is an overall 30.5 percent decrease in the fall rate for medical, surgical, and intensive care units (ICU). In addition, there were no reported musculoskeletal injuries involving nursing staff for FYs 2006 and 2007.

In 2007, the medical center submitted the Fall Reduction Program to the VA Office of Nursing Services Innovation Awards program, and it was recognized as one of the top 10 programs for evidenced-based nursing practice. The program serves as a catalyst for new, creative ideas that are initiated and led by VA nursing staff.

Results

Review Activities With Recommendations

Quality Management

The purpose of this review was to evaluate whether the medical center's QM program provided comprehensive oversight of the quality of care and whether senior managers actively supported the program's activities. We interviewed the medical center's senior management team and QM

personnel. We evaluated plans, policies, and other relevant documents.

The QM program was generally effective in providing oversight of the medical center's quality of care, and senior managers supported the program. Appropriate review structures were in place for 12 of the 14 program activities reviewed.

The medical center has accomplished significant improvements in their peer review process since the last CAP review. During the 2nd quarter of FY 2008, peer review data indicated that timeliness of completion continued to be a problem. The new Quality Manager implemented improvement actions, and all reviews from the 3rd and 4th quarters of FY 2008 met VHA timeliness standards. We encouraged the medical center to maintain these improvements.

We identified two areas that continued to need improvement. Both had been previously identified during our prior CAP review.

Data Trending, Analysis, and Reporting. Although the medical center had implemented improvements in overall committee structure and reporting functions, managers did not consistently trend and analyze data, discuss results, plan actions, and follow up on the effectiveness of actions in all areas required by VHA and The Joint Commission (JC). The local performance improvement plan designates a clear, systematic process for monitoring important functions, collecting and reporting data, evaluating the results of actions for improvement, and assessing effectiveness of actions. Results are to be communicated through designated committees and documented in committee minutes. Medical center leaders need to receive adequate information in order to make decisions to improve care.

Blood Utilization Committee minutes had all of the required data reported but lacked trending, discussion, actions, and follow-up.

The medical center lacked data from ongoing medical record reviews. We reviewed monthly Medical Record Committee minutes from January 2008 through September 2008. Minutes were brief and did not include significant data. The June minutes noted a delinquency rate of 46 percent for

completion of discharge summaries, but the subsequent monthly minutes stated that data was unavailable and concluded with "they will try to have the data for the next month's meeting." No further data or actions were reported. The JC requires that information found in the patient medical record be readily accessible, accurate, complete, organized, and timely. The medical center cannot determine if their medical records meet these requirements without data from reviews.

ICU Committee minutes did not consistently contain analysis of data, discussion, actions, and follow-up. For example, the medical center collected data on resuscitations and reported individual cases to the ICU Committee, but this data had not been trended over time. It is difficult to determine if trends are present, if actions are needed, or if improvements have occurred without a consistent process in place.

Adverse Event Disclosure. The medical center did not document disclosure of adverse events, as required by VHA and local policy. One adverse event occurred in July 2008 that required both clinical and institutional disclosure.[2] Local policy states that disclosure will be communicated promptly to patients and/or patients' families and documented in a template progress note in the electronic medical record. We were told that disclosure occurred at the time of the event, but it was not documented in the medical record.

Although the medical center completed the disclosure note during our review indicating both clinical and institutional disclosure, the event occurred 3 months earlier. Medical centers have an obligation to provide timely disclosure.

Recommendation 1 We recommended that the VISN Director ensure that the Medical Center Director requires that QM data are consistently trended, analyzed, and routinely reported to the appropriate oversight committee and that committee minutes document discussion, actions, and follow-up.

The VISN and Medical Center Directors concurred with our findings and recommendation. The Quality Manager is developing a tracking mechanism and reporting structure to ensure that all committees follow the guidelines in a timely

[2] Clinical disclosure is the forthright, empathetic discussion of clinically significant facts of an adverse event that involves actual or potential harm to a patient sustained during his or her care. Institutional disclosure is required in cases resulting in serious injury or death and in cases involving potential liability. Institutional disclosures include an apology and information about procedures available to obtain compensation.

manner using a standardized format and provide the information to the appropriate structure for discussion and action, if necessary. We find this action plan appropriate and will follow up on reported implementation actions to ensure completion.

Recommendation 2 We recommended that the VISN Director ensure that the Medical Center Director requires that all adverse events that meet disclosure requirements be communicated and documented in accordance with VHA and local policy.

The VISN and Medical Center Directors concurred with our findings and recommendation. All adverse events will be tracked and followed to ensure timeliness and completion. We find this action plan appropriate and will follow up on reported implementation actions to ensure completion.

Environment of Care

The purpose of this review was to determine if VHA medical centers maintain a safe and clean health care environment. Medical centers are required to provide a comprehensive EOC program that fully meets VHA National Center for Patient Safety, Occupational Safety and Health Administration, and JC standards.

We inspected outpatient clinic areas, the inpatient unit, the ICU, the CLC, the laboratory area, the physical therapy/occupational therapy area, and radiology. The medical center maintained a generally clean and safe environment. Nurse managers and unit staff expressed satisfaction with the responsiveness of the housekeeping staff on their units.

We identified the following areas that needed improvement:

Emergency Cart Checks. Medical center staff did not consistently check emergency carts once each shift, as required by local policy. Three of seven crash cart checks did not have consistent documentation of emergency equipment review. Checking emergency carts each shift ensures that proper equipment is readily available and functioning in case of emergency.

Medication Refrigerator Monitoring. Staff did not consistently conduct daily medication refrigerator monitoring, as required by local policy. All three inpatient units had one or more days where staff did not check and document the temperatures of medication refrigerators. Medications that

require refrigeration can become unstable when not stored at the proper temperature.

Hand Hygiene. Hand hygiene compliance data was not consistently compiled in accordance with local policy. Local policy requires that the volume of hand hygiene product used be monitored quarterly. We reviewed the Infection Control (IC) Committee minutes for the past 4 quarters, and there was no review of this requirement. Local policy also requires that staff hand hygiene compliance be monitored on a monthly basis. Nine of 10 clinical areas had not consistently compiled monthly data.

Also, VHA requires that medical centers have a process for monitoring health care workers' adherence to the required hand hygiene practices and for providing information regarding their performance in order to reduce infection risks for patients and staff.

Recommendation 3 We recommended that the VISN Director ensure that the Medical Center Director requires staff to check emergency carts in accordance with local policy.

The VISN and Medical Center Directors concurred with our finding and recommendation. The emergency cart checklist has been modified. Checklists are monitored on a daily basis and tracked to ensure completion. We find this action plan appropriate and will follow up on reported implementation actions to ensure completion.

Recommendation 4 We recommended that the VISN Director ensure that the Medical Center Director requires staff to monitor medication refrigerators, as required by local policy.

The VISN and Medical Center Directors concurred with our finding and recommendation. A standardized temperature log has been implemented and is monitored daily by the unit manager or charge nurse. Results are reported for tracking purposes. We find this action plan appropriate and will follow up on reported implementation actions to ensure completion.

Recommendation 5 We recommended that the VISN Director ensure that the Medical Center Director requires that staff consistently collect hand hygiene compliance data in accordance with local policy.

The VISN and Medical Center Directors concurred with our findings and recommendation. All clinics are required to collect hand hygiene data and report results to the IC nurse. The IC nurse is tracking each clinic to ensure compliance. Tracked and trended data are reported to the appropriate committee for review. We find this action plan appropriate and will follow up on reported implementation actions to ensure completion.

Coordination of Care

The purpose of this review was to evaluate whether inpatient consultations, transfers, and discharges were coordinated appropriately and met VHA and JC standards. Coordinated consultations, transfers, and discharges are essential to an integrated, ongoing care process resulting in optimal patient outcomes.

We reviewed the medical records of nine inpatients that had consults ordered and performed internally. In general, we found that inpatients received consultative services within acceptable timeframes. All nine intra-facility transfers we reviewed had the required medical record documentation specified by local policy.

We identified the following area that needed improvement:

Discharge Documentation. None of the nine discharges reviewed had the locally required medical record documentation. According to local policy, discharge instructions must have an additional signature by the primary care provider, and the patient must sign discharge instructions to verify receipt. Neither of these two elements was present for the nine records reviewed. Documentation and communication of patient health information enhances continuity and coordination of care.

Recommendation 6 We recommended that the VISN Director ensure that the Medical Center Director requires staff to complete discharge documentation, as required by local policy.

The VISN and Medical Center Directors concurred with our findings and recommendation. Medical center policy has been modified to reflect the standard of practice. We find this action plan appropriate and will follow up on reported implementation actions to ensure completion.

Emergency Department/Urgent Care Clinic

The purpose of this review was to evaluate whether VHA facility ED/UCCs complied with VHA guidelines related to hours of operation, clinical capability (including management of patients with acute mental health conditions and patients transferred to other facilities), staffing adequacy, and staff competency. In addition, we inspected the medical center's ED/UCC for cleanliness and safety.

The ED/UCC is open 24 hours per day, 7 days per week and is located within the main hospital building. The emergency services provided are within the medical center's patient care capabilities. There is an appropriate policy for managing patients whose care may exceed the medical center's capability.

We reviewed medical records of patients who presented in the ED/UCC with acute mental health conditions, and in all cases, we found that staff managed the patients' care appropriately.

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

We determined that the ED/UCC complied with VHA operational standards, including staffing guidelines, cleanliness, and competency. However, the following area needed improvement:

Inter-Facility Transfers. ED/UCC staff did not document specific inter-facility transfer data, as required by VHA[3] and local policy. The movement of acutely ill people from one institution to another exposes them to risks. Failing to transfer patients may be equally risky. VHA has the responsibility to ensure that transfers into and out of its medical facilities are carried out appropriately to assure maximum patient safety and to comply with the intent of the Emergency Medical Treatment and Labor Act.

None of the medical records we reviewed contained all the required documentation elements. During onsite interviews, ED/UCC staff located and identified their local electronic inter-facility transfer policy and template. However, they

[3] VHA Directive 2007-015, *Inter-Facility Transfer Policy*, May 7, 2007.

confirmed that they had not used the template. Staff also confirmed that their inter-facility transfer notes did not include all required documentation elements.

Recommendation 7 We recommended that the VISN Director ensure that the Medical Center Director requires ED/UCC staff to complete inter-facility transfer documentation, as required by VHA and local policy.

The VISN and Medical Center Directors concurred with our finding and recommendation. The Chief of Medicine has communicated the policy to all ED clinicians. The Chief of ED will ensure compliance. We find this action plan appropriate and will follow up on reported implementation actions to ensure completion.

Pharmacy Operations

The purpose of this review was to evaluate whether VA health care facilities had adequate controls to ensure the security and proper management of controlled substances and the pharmacy's internal physical environment. We also determined whether clinical managers had processes in place to monitor patients prescribed multiple medications to avoid polypharmacy, especially in vulnerable populations.

We assessed whether the medical center's policies and practices were consistent with VHA regulations governing pharmacy and controlled substances security.[4] In addition, we reviewed policies and procedures and interviewed appropriate personnel to determine if clinical pharmacists monitored patients prescribed multiple medications to avoid polypharmacy. We inspected the pharmacy's inpatient and outpatient operations for security, EOC, and IC concerns, and we interviewed appropriate Pharmacy Service personnel as necessary.

Pharmacy Controls. The medical center had appropriate policies and procedures to ensure the security of the pharmacy and controlled substances. The internal pharmacy environment was secure, clean, and well maintained. The sterile preparation area's Class 5 hood,

[4] VHA Handbook 1108.1, *Controlled Substances (Pharmacy Stock),* October 4, 2004; VHA Handbook 1108.2, *Inspection of Controlled Substances*, August 29, 2003; VHA Handbook 1108.5, *Outpatient Pharmacy*, May 30, 2006; VHA Handbook 1108.6, *Inpatient Pharmacy*, June 27, 2006.

where sterile intravenous medications were prepared, complied with VHA regulations[5] and IC standards.

Polypharmacy. Pharmacological regimens involving multiple medications are often necessary to prevent and maintain disease states; however, excessive use of medications can result in adverse reactions and increased risks of complications. Polypharmacy is more complex than just the number of drugs that patients are prescribed. The clinical criteria to identify polypharmacy are the use of: (a) medications that have no apparent indication, (b) therapeutic equivalents to treat the same illness, (c) medications that interact with other prescribed drugs, (d) inappropriate medication dosages, and (e) medications to treat adverse drug reactions.[6] Some literature suggests that elderly patients and mental health patients are among the most vulnerable populations for polypharmacy.[7] Clinical pharmacists identified all patients who were prescribed multiple medications, reviewed their medication regimens to avoid polypharmacy, and advised providers as appropriate.

We identified the following areas that needed improvement:

Controlled Substances Inspections. While assigned staff conducted the inspections according to VHA regulations, and training records documented that the CSC, the Alternate CSC, and all inspectors received appropriate training to execute their duties, we noted two areas of the program that did not meet VHA regulations.

The medical center's Director appointed a registered nurse as the CSC in August 2007. This nurse is a clinical case manager with a permanent work assignment in an area where controlled substances are administered. VHA regulations specify that inspectors, including coordinators, cannot be staff who are involved in procuring, prescribing, dispensing, or administering drugs.

The Chief of Staff signed the controlled substances inspectors' appointment letters. VHA regulations state that

[5] VHA Handbook 1108.6.
[6] Yvette C. Terrie, BSPharm, RPh, "Understanding and Managing Polypharmacy in the Elderly," *Pharmacy Times,* December 2004.
[7] Terrie, *Pharmacy Times*, December 2004; Vijayalakshmy Patrick, M.D., et al., "Best Practices: An Initiative to Curtail the Use of Antipsychotic Polypharmacy in a State Psychiatric Hospital," *Psychiatric Services*, 57:21–23, January 2006.

the medical center's Director has the responsibility to sign all appointment letters, not the Chief of Staff.

Pharmacy Vault Day Gate. The self-closing and locking mechanism of the day gate in the pharmacy vault was broken, and the spring did not automatically close upon entry. Staff submitted a work order 2 months prior to our site visit, but engineering staff had not corrected the malfunction. An automatic locking mechanism ensures the security of bulk controlled substances.

Pharmacy Refrigerator Temperature Monitoring. Pharmacy staff did not consistently check and document daily refrigerator temperatures for three pharmacy refrigerators. The JC requires that medications be properly and safely stored to guarantee chemical stability and maximum efficacy.

Recommendation 8 We recommended that the VISN Director ensure that the Medical Center Director appoints a non-clinical CSC.

The VISN and Medical Center Directors concurred with our finding and recommendation. A non-clinical CSC has been appointed and is now managing the program. We find this corrective action acceptable, and we consider this recommendation closed.

Recommendation 9 We recommended that the VISN Director ensure that the Medical Center Director signs appointment letters for controlled substances inspectors.

The VISN and Medical Center Directors concurred with our finding and recommendation. The Medical Center Director has signed all appointment letters for controlled substances inspectors. We find this corrective action acceptable, and we consider this recommendation closed.

Recommendation 10 We recommended that the VISN Director ensure that the Medical Center Director requires the repair of the pharmacy vault day gate.

The VISN and Medical Center Directors concurred with our finding and recommendation. The pharmacy vault gate has been repaired. We find this corrective action acceptable, and we consider this recommendation closed.

Recommendation 11 We recommended that the VISN Director ensure that the Medical Center Director requires staff to monitor

temperatures and document daily temperature checks for the pharmacy refrigerators.

The VISN and Medical Center Directors concurred with our findings and recommendation. The Chief of Pharmacy has made a staffing adjustment. Multiple pharmacists are now responsible and accountable for verifying temperature checks. We find this action plan appropriate and will follow up on reported implementation actions to ensure completion.

Review Activities Without Recommendations

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 selected medication management processes in the inpatient medical/surgical unit, the CLC, and the ICU. We found adequate management of medications brought into the facility by patients or their families. Nurses appropriately scanned patient armbands and used personal identifiers to correctly identify patients prior to medication administration. In addition, staff documented the effectiveness of pain medications and other patient requested medications within 4 hours after administration, as required by local policy.

Because we found no discrepancies between policy and medication management clinical practices, we made no recommendations.

Physician Privileges

The purpose of this review was to determine whether the medical center had processes in place to ensure that physicians are granted only those privileges for which they have demonstrated competence.

We randomly selected a sample of physicians from each clinical service who were repriviliged or hired within the previous 12 months. Our review consisted of a total of 18 physicians' information from the following services: (a) medicine, (b) surgery, (c) anesthesia, (d) mental health, (e) radiology, and (f) laboratory/pathology. We reviewed the physicians' privileging information, the Executive Committee of the Medical Staff minutes/discussions at time of hire or reprivileging, and QM data collected on actual clinical performance. Information supported the privileges listed for the 18 physicians.

The Medical Staff Coordinator extracts monthly performance measure data from the VISN 19 Data Warehouse. Information from the warehouse is customized, filtered, and compiled onto a spreadsheet that demonstrates each provider's compliance to VHA performance measures. This critical step improves the service line director's evaluation process for each provider. Also, the Medical Staff Coordinator, in conjunction with the clinical departments, developed review forms. The standardization of review forms combined with the use of the customized information extracted from the warehouse has resulted in an effective and comprehensive credentialing and privileging program.

We made no recommendations.

Staffing

The purpose of this review was to evaluate whether VHA facilities had developed comprehensive staffing guidelines and whether the guidelines had been met. We found that the medical center had developed a Nursing Service staffing plan and unit-based nurse staffing guidelines, and we found them to be adequate.

The medical center uses expert panel as the primary staffing methodology. Nurse managers adjust staffing based on patient acuity levels; average daily census; and frequency of patient admissions, transfers, and discharges on a shift-by-shift basis. The Nursing Service staffing plan is reviewed and adjusted annually.

We reviewed staffing for all inpatient units and for the outpatient clinics for a total of 10 shifts. We looked at one holiday, one Saturday, and one Wednesday for all units. We found that local guidelines for nurse staffing were met in all areas reviewed and that specific actions had been taken to ensure safe patient care, including the use of compensatory time and overtime when needed. Also, the medical center has added additional CBOC nursing staff due to projected growth in patient enrollment. We found nurse staffing adequate in all patient care areas.

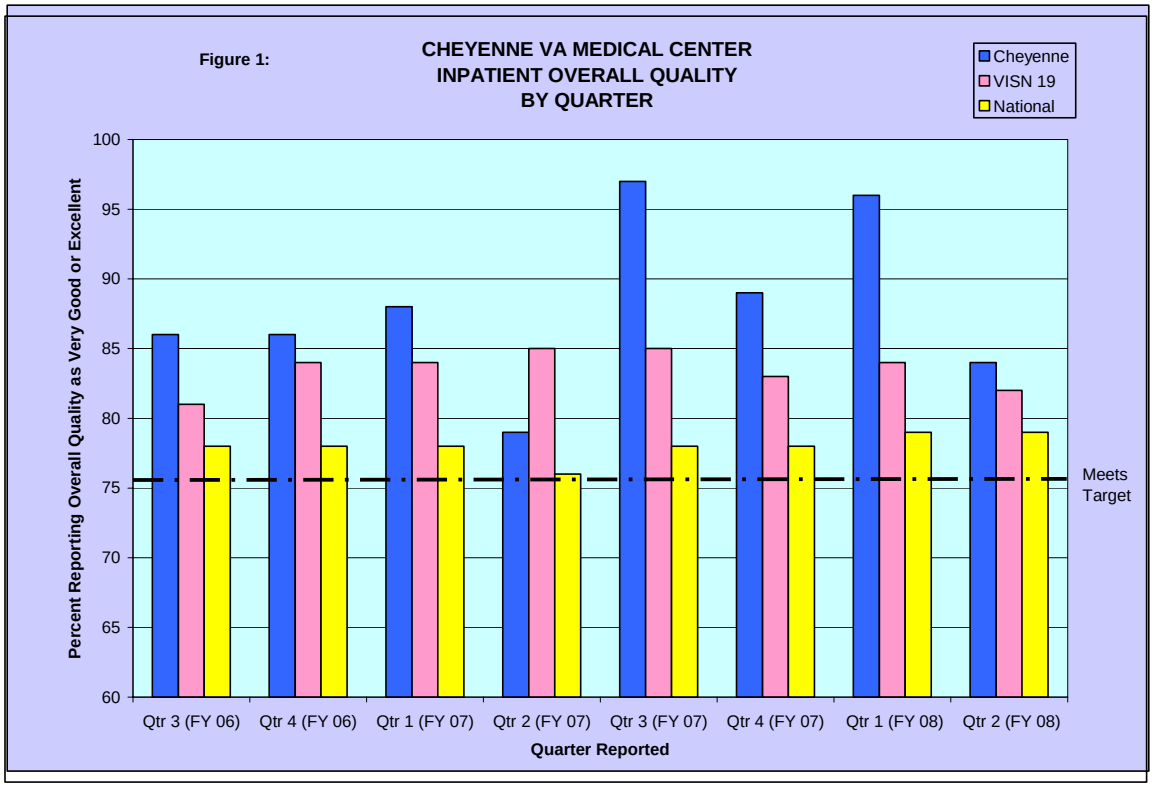
We made no recommendations.

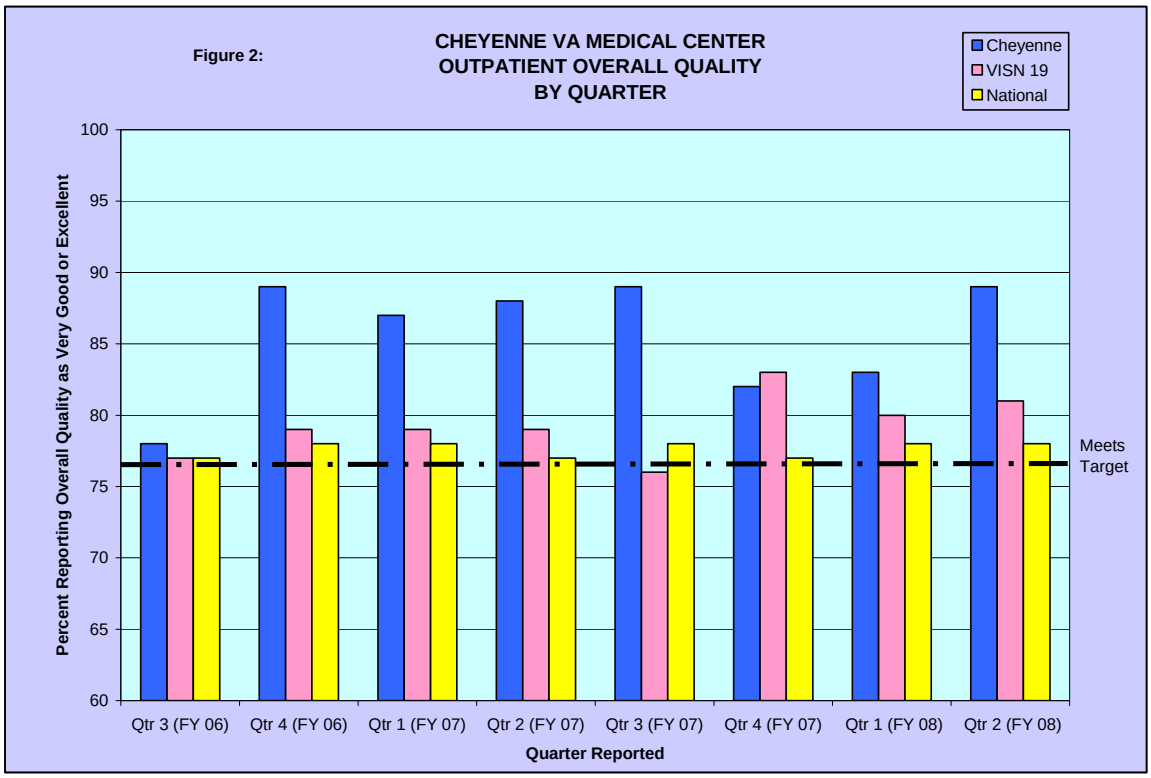
Survey of Healthcare Experiences of Patients

The purpose of this review was to assess the extent that VHA medical centers use quarterly survey results of patients' health care experiences with the VHA system to improve patient care, treatment, and services. The Performance Analysis Center for Excellence of the Office of Quality and

Performance within VHA is the analytical, methodological, and reporting staff for SHEP. VHA set performance measure goals for patients reporting overall satisfaction of "very good" or "excellent" at 76 percent for inpatients and 77 percents for outpatients. Medical centers are expected to address areas that fall below target scores.

We reviewed the inpatient and outpatient survey results for each quarter, beginning with the 3rd quarter of FY 2006 and ending with the 2nd quarter of FY 2008. Figures 1 and 2 below and on the next page show the medical center's SHEP performance measure results for inpatients and outpatients, respectively.





The medical center exceeded the target score and the national average score for each quarter we reviewed. The medical center's Director shares SHEP data with staff, service chiefs, and patients. The Performance Improvement Executive Group has oversight responsibility for patient satisfaction and includes representatives from various services.

We made no recommendations and congratulated the medical center on their outstanding patient satisfaction scores.

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: November 12, 2008

From: Director, Rocky Mountain Network (10N19)

Subject: **Combined Assessment Program Review of the Cheyenne VA Medical Center, Cheyenne, Wyoming**

To: Director, Kansas City Regional Office of Healthcare Inspections (54KC)

Director, Management Review Service (10B5)

I concur with all corrective actions and processes in place at the Cheyenne VAMC to address the findings and recommendations in the draft OIG CAP review.

Glen W. Grippen, FACHE

Appendix B

Medical Center Director Comments

Department of Veterans Affairs **Memorandum**

Date: November 6, 2008

From: Director, Cheyenne VA Medical Center (442/00)

Subject: **Combined Assessment Program Review of the Cheyenne VA Medical Center, Cheyenne, Wyoming**

To: Director, Rocky Mountain Network (10N19)

I have reviewed the draft report of the Inspector General's Combined Assessment Program (CAP) of the Cheyenne VA Medical Center and concur with the findings and recommendations. We have initiated corrective actions and have processes in place to address the findings and recommendations.

On behalf of the entire medical center, we appreciate the opportunity for this review as a continuing process to improve care to our veterans. We take pride in serving those whom have served our nation.

David M. Kilpatrick, M.D.

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 Medical Center Director requires that QM data are consistently trended, analyzed, and routinely reported to the appropriate oversight committee and that committee minutes document discussion, actions, and follow-up.

Concur

The Quality Manager is in the process of developing a tracking mechanism and reporting structure to ensure that all committees follow the guidelines in a timely and standard format as well as providing the information to the appropriate structure for discussion and action if necessary.

Recommendation 2. We recommended that the VISN Director ensure that the Medical Center Director requires that all adverse events that meet disclosure requirements be communicated and documented in accordance with VHA and local policy.

Concur

All adverse events will be tracked and followed using two person/two department integrity to ensure timeliness and completion.

Recommendation 3. We recommended that the VISN Director ensure that the Medical Center Director requires staff to check emergency carts in accordance with local policy.

Concur

The emergency cart checklist has been modified for ease of use, monitored on a daily basis, and reported to the nursing office for tracking.

Recommendation 4. We recommended that the VISN Director ensure that the Medical Center Director requires staff to monitor medication refrigerators, as required by local policy.

Concur

A standardized temperature log has been implemented, monitored daily by the unit manager or charge nurse; results are reported to the nursing office for tracking.

Recommendation 5. We recommended that the VISN Director ensure that the Medical Center Director requires that staff consistently collect hand hygiene compliance data in accordance with local policy.

Concur

All Clinics are required to collect hand hygiene data and report to the infection control nurse. The infection control nurse is tracking each clinic and ensuring compliance. Reports are being generated with the data, tracked and trended, and reported to the appropriate committee for review.

Recommendation 6. We recommended that the VISN Director ensure that the Medical Center Director requires staff to complete discharge documentation, as required by local policy.

Concur

The Medical Center Policy has been modified to reflect the standard of practice and intent of compliance with the standard.

Recommendation 7. We recommended that the VISN Director ensure that the Medical Center Director requires ED/UCC staff to complete inter-facility transfer documentation, as required by VHA and local policy.

Concur

The Chief of Medicine has communicated the policy to all ED Clinicians. The Chief of ED is ensuring compliance and communicating back to the Medicine Department.

Recommendation 8. We recommended that the VISN Director ensure that the Medical Center Director appoints a non-clinical CSC.

Concur

A non-clinical CSC has been appointed and now managing the program.

Recommendation 9. We recommended that the VISN Director ensure that the Medical Center Director signs appointment letters for controlled substances inspectors.

Concur

All appointment letters for controlled substance inspectors have been signed by the Medical Center Director.

Recommendation 10. We recommended that the VISN Director ensure that the Medical Center Director requires the repair of the pharmacy vault day gate.

Concur

Pharmacy vault gate has been repaired.

Recommendation 11. We recommended that the VISN Director ensure that the Medical Center Director requires staff to monitor temperatures and document daily temperature checks for the pharmacy refrigerators.

Concur

The Chief of Pharmacy has made a staffing adjustment and has multiple pharmacists responsible and accountable for verifying the temperature check.

OIG Contact and Staff Acknowledgments

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