Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 08-03042-65

Combined Assessment Program Review of the Central Arkansas Veterans Healthcare System Little Rock, Arkansas

February 4, 2009

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 November 3–7, 2008, the OIG conducted a Combined Assessment Program (CAP) review of the Central Arkansas Veterans Healthcare System (the system), Little Rock, AR. The purpose of the review was to evaluate selected operations, focusing on patient care administration and quality management (QM). During the review, we also presented fraud and integrity awareness training to 627 system employees. The system is part of Veterans Integrated Service Network (VISN) 16.

Results of the Review

The CAP review covered eight operational activities. We identified the following organizational strength:

- Transforming care at the bedside.

We made recommendations in four of the activities reviewed. For these activities, the system needed to:

- Display suicide prevention posters and brochures throughout the system.
- Require that environment of care (EOC) performance measures (PMs) meet Veterans Health Administration (VHA) standards.
- Designate responsibility for monitoring and maintaining the WanderGuard® system and ensure compliance.
- Incorporate all responsibilities of the Controlled Substances (CS) Coordinator into the local policy.
- Ensure that the vault in the North Little Rock outpatient pharmacy is in compliance with VA standards and guidelines.
- Require that provider performance improvement (PI) data be collected, analyzed, reviewed, considered as part of the reprivileging process, and recorded in Professional Standards Board (PSB) minutes.
- Ensure that designated staff maintain current Basic Life Support (BLS) and/or Advanced Cardiac Life Support (ACLS) certification, in accordance with local policy.
- Define a specific timeframe for assessing pain medication effectiveness and document responses in a timely manner.

The system complied with selected standards in the following four activities:

- Coordination of Care.
- Emergency/Urgent Care Operations.
- Staffing.
- Survey of Healthcare Experiences of Patients (SHEP).

This report was prepared under the direction of Linda G. DeLong, Director, Dallas Office of Healthcare Inspections.

Comments

The VISN and System Directors agreed with the CAP review findings and recommendations and provided acceptable improvement plans. (See Appendixes A and B, pages 15–21, 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 system is a tertiary care facility that provides a broad range of inpatient and outpatient health care services. Outpatient care is also provided at five community based outpatient clinics in El Dorado, Hot Springs, Mena, Mountain Home, and Pine Bluff, AR. The system is part of VISN 16 and serves a veteran population of about 170,000 throughout 46 counties in Arkansas.

Programs. The system provides primary, tertiary, and long-term care in the areas of medicine, surgery, mental health, physical medicine and rehabilitation, neurology, dentistry, geriatrics, and extended care. It has 294 hospital beds and 177 community living center (CLC)[1] beds.

Affiliations and Research. The system is affiliated with the University of Arkansas for Medical Sciences and provides training for 162 residents and for 1,422 students in other disciplines. In fiscal year (FY) 2008, the system's research program had 445 projects and a budget of $9.8 million. Important areas of research include cardiology, endocrinology, and surgery.

Resources. In FY 2008, medical care expenditures totaled $414 million. The FY 2009 medical care budget is approximately $431 million. FY 2008 staffing was 2,808 full-time employee equivalents (FTE), including 173 physician and 899 nursing FTE.

Workload. In FY 2008, the system treated 67,573 unique patients and provided 73,089 inpatient days in the hospital and 48,134 inpatient days in the CLC units. The inpatient care workload totaled 11,183 discharges, and the average daily census, including CLC patients, was 331. Outpatient workload totaled 561,740 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 eight activities:

- Coordination of Care.
- Emergency/Urgent Care Operations.
- EOC.
- Medication Management.
- Pharmacy Operations and CS Inspections.
- QM.
- SHEP.
- Staffing.

The review covered system operations for FYs 2007, 2008, and 2009 through November 3, 2008, and was done in accordance with OIG standard operating procedures for CAP reviews. As part of our review, we followed up on recommendations from our prior CAP review of the system *(Combined Assessment Program Review of the Central Arkansas Veterans Healthcare System, Little Rock, AR,* Report No. 05-01837-214, September 30, 2005). The system had corrected all findings related to health care from our prior CAP review.

During this review, we also presented fraud and integrity awareness briefings for 627 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

Transforming Care at the Bedside

The system participates with the American Organization of Nurse Executives in the Robert Wood Johnson Foundation's Transforming Care at the Bedside (TCAB) dissemination project. The system is one of four VA facilities across the country participating. TCAB is designed to improve the quality and safety of patient care on medical and surgical units, increase the vitality and retention of nurses, and improve the effectiveness of the entire team. The program engages nurses to develop interventions and design new processes that improve care and lead to better staff morale.

On the hematology, oncology, palliative, and education units, TCAB started with staff education on brainstorming, deep dive, snorkeling, and rapid cycle "test of change" techniques. Weekly discussions are led by staff. Final decisions are made to determine which ideas to implement. Staff are empowered to make these decisions, and over 90 changes have been implemented, including use of a "Do NOT Disturb" sign during medication administration, placement of a monthly calendar at each patient's bedside with the admission date circled, installation of hand sanitizers at each patient's bedside, installation of a Yacker Tracker to decrease noise, provision of a scripting note to patients upon discharge, and performance of hourly rounds.

As a result of this project, system staff have increased respect for each other and each other's ideas, and team cohesiveness and participation in overtime have increased. There have been statistically significant changes in staff satisfaction and perception of job control. Staff turnover has decreased, and nurse time at the bedside has increased. Patient satisfaction has also increased. TCAB has demonstrated that small changes have the potential of making the greatest impact on patient safety and staff satisfaction.

Results

Review Activities With Recommendations

Environment of Care

The purpose of this review was to determine if the system maintained a safe and clean health care environment. The system is required to provide a comprehensive EOC program that fully meets VA National Center for Patient Safety, Occupational Safety and Health Administration, and Joint Commission (JC) standards. The infection control (IC) program was evaluated to determine compliance with VHA directives based on the management of data collected and processes in which the data was used to improve performance.

We inspected the telemetry unit, the surgical intensive care unit, medical and surgical units, the domiciliary, CLC units, locked acute inpatient mental health units, and primary care and specialty clinics. The system maintained a generally clean environment. The IC program monitored and reported data to clinicians for implementation of quality improvements. However, we identified the following conditions that needed improvement.

Suicide Prevention Information. A Deputy Under Secretary for Health for Operations and Management memorandum issued on December 7, 2007, requires suicide prevention posters and brochures to be displayed in highly visible areas throughout the system. We did not find suicide prevention posters and brochures consistently displayed in highly visible areas at the Little Rock campus. However, we did find some posters displayed at the North Little Rock campus. While we were onsite, suicide prevention posters were distributed throughout the Little Rock campus.

Environment of Care Deficiency Monitors. EOC inspections identify concerns for appropriate actions. Facilities are required to inspect administrative and clinical areas semi-annually to identify environmental deficiencies and initiate timely resolutions. To monitor EOC PMs, facilities are required to develop a tool to track and trend EOC inspections, the deficiencies identified, and the corrective actions taken. The standard to meet is 85 percent or better. The system did not meet the standard in 2 of the last 4 quarters for deficiencies corrected within 14 days. Additionally, the system did not meet the standard for the last 4 quarters for deficiencies that cannot be corrected

within 14 days but have been addressed with a plan for action. However, overall percentages did steadily increase over the last 4 quarters.

Safety. To minimize the risk of patients wandering away from designated areas, VHA outlines standards for monitoring and maintaining electronic systems, such as WanderGuard®.[2] A basic system check should occur every 24 hours to assure proper functioning. The system did not have a policy in place that designated responsibility for monitoring and maintaining the WanderGuard® system on the CLC units. Clinical staff on CLC I monitored the WanderGuard® system and patients' bracelets every 24 hours. However, staff on CLC II monitored only the patients' bracelets every 24 hours. Maintenance of the WanderGuard® system should be consistent with the manufacturer's guidelines, and a complete check must be performed annually. The system was in the process of revising the local policy during our site visit.

Recommendation 1 We recommended that the VISN Director ensure that the System Director requires that suicide prevention posters and brochures are displayed in highly visible areas throughout the system.

The VISN and System Directors agreed with the CAP review findings and recommendation. They reported that during our site visit, suicide prevention posters were placed in highly visible areas, including the emergency room, atria waiting rooms, and all waiting areas and unit entry points at both campuses. The corrective action is acceptable, and we consider this recommendation closed.

Recommendation 2 We recommended that the VISN Director ensure that the System Director requires that EOC PMs meet VHA standards.

The VISN and System Directors agreed with the CAP review findings and recommendation. They reported that reminders will be sent to service chiefs for all deficiencies identified as 10 days old. Any unresolved issues will be forwarded for resolution. They also reported that any current deficiencies over 14 days old that did not require project funding would be corrected/abated by January 9, 2009. The improvement

[2] WanderGuard® is an electronic elopement management system.

plan is acceptable, and we will follow up on the completion of the planned actions.

Recommendation 3 We recommended that the VISN Director ensure that the System Director requires that local policy clearly designate responsibility for monitoring and maintaining the WanderGuard® system and that compliance is ensured.

The VISN and System Directors agreed with the CAP review findings and recommendation. They reported that the system currently has a process to monitor patients using the WanderGuard® system and that results are documented. A service-wide plan for the system has been developed and will be implemented. 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 VA health care facilities had adequate controls to ensure the security and proper management of CS and the pharmacies' internal physical environments. We also determined whether clinical managers had processes in place to monitor patients prescribed multiple medications to avoid polypharmacy, especially in vulnerable populations.

We reviewed VHA regulations[3] governing pharmacy and CS security, and we assessed whether the system's policies and practices were consistent with VHA regulations. We inspected inpatient and outpatient pharmacies for security, EOC, and IC concerns. Additionally, we reviewed policies and procedures, and we interviewed the CS Coordinator, pharmacy managers, and the Chief of Police.

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

[3] 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.

(e) medications to treat adverse drug reactions.[4] Some literature suggests that elderly patients and mental health patients are among the most vulnerable populations for polypharmacy.[5] Our review showed that managers followed processes to ensure that medication regimens were reviewed for patients who were prescribed multiple medications to avoid polypharmacy.

CS inspections were conducted according to VHA regulations. Training records showed that the CS Coordinator and inspectors received appropriate training to execute their duties. We also found that managers reported all CS diversions or suspected diversions to the OIG. The pharmacies' internal environments were clean and well maintained. We identified the following areas that needed improvement.

Controlled Substances Coordinator Responsibilities. VHA policy defines CS Coordinator responsibilities, but the local policy did not include all outlined responsibilities. Without clear designation of responsibility, significant tasks may be neglected. While we were onsite, the local policy was revised.

Vault Security. According to VA policy[6] and the local annual physical security survey, the vault at the North Little Rock campus did not meet standards. In January 2008, findings of the annual physical security survey showed the drug storage container to be inadequate, and the Chief of Police recommended constructing a Type II vault to enable the pharmacy to store Schedule I, II, and III narcotic CS. Our inspection of the vault revealed a safe that was too small, and we found medications packaged to be mailed sitting on the floor around the safe. In order to meet current regulations, the system needed to install a General Services Administration Class 5 vault door. Because a wall needed to be reconstructed, the vault door had not been installed as of our site visit.

[4] Yvette C. Terrie, BSPharm, RPh, "Understanding and Managing Polypharmacy in the Elderly, *Pharmacy Times*, December 2004.
[5] 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.
[6] VA Handbook 0730, *Security and Law Enforcement*, August 11, 2000.

Recommendation 4 We recommended that the VISN Director ensure that the System Director requires that all responsibilities of the CS Coordinator are incorporated into the local policy.

The VISN and System Directors agreed with the CAP review finding and recommendation. They reported that the local policy has been revised to include all CS Coordinator responsibilities. The corrective action is acceptable, and we consider this recommendation closed.

Recommendation 5 We recommended that the VISN Director ensure that the System Director requires that the vault in North Little Rock outpatient pharmacy is in compliance with VA standards and guidelines.

The VISN and System Directors agreed with the CAP review findings and recommendation. They reported that the North Little Rock outpatient pharmacy vault enclosure will be built by an outside contractor. The expected completion date is February 1, 2009. The system's Engineering Service will perform the finishing work. The improvement plan is acceptable, and we will follow up on the completion of the planned actions.

Quality Management

The purpose of this review was to evaluate whether the system had a comprehensive QM program designed to monitor patient care and whether senior managers actively supported the program's activities. We evaluated policies, PI data, and other relevant documents. We interviewed appropriate senior managers and the QM Coordinator. The system's QM program was generally effective, and senior managers supported the program through participation in and evaluation of PI initiatives and through allocation of resources to the program. However, we identified the following areas that needed improvement.

Provider Performance Monitoring. VHA regulations[7] and JC standards require that clinical managers develop plans for continuous performance monitoring of the medical staff. According to the requirements, performance data should be ongoing, include indicators for continuing qualifications and competencies, be reviewed and considered during the reprivileging process, and be recorded in PSB minutes.

[7] VHA Handbook 1100.19, *Credentialing and Privileging*, October 2, 2007.

At the time of our site visit, plans for ongoing physician competency monitoring had been developed. We reviewed credentialing and privileging folders and corresponding PI data for 32 providers reprivileged in the past 12 months. We found that 24 (75 percent) of 32 providers had inadequate data recorded in PSB minutes to support the privileges granted.

Resuscitation and Outcomes. We found that the system did not have a mechanism in place to consistently review staff compliance with current BLS and/or ACLS certification, as required by local policy. We reviewed documentation for staff required to have current BLS certification and found that 70 (6 percent) of the 1,173 certifications had expired. Also, we identified that 16 (4 percent) of 421 providers required to have ACLS certification had expired certifications. Without ongoing review of compliance with BLS and ACLS standards, the system cannot be assured that quality care and patient safety is ensured when life-threatening events occur.

Recommendation 6 We recommended that the VISN Director ensure that the System Director requires that provider PI data are collected, analyzed, reviewed, considered as part of the reprivileging process, and recorded in PSB minutes.

The VISN and System Directors agreed with the CAP review findings and recommendation. They reported that service chiefs will be required to discuss the results of their focused professional practice evaluation (FPPE) reviews and ongoing professional practice evaluation (OPPE) reviews at PSB meetings. Discussions of FPPE reviews will be held on at least a semi-annual basis, and discussions of OPPE reviews will be held on at least an annual basis. The improvement plan is acceptable, and we will follow up on the completion of the planned actions.

Recommendation 7 We recommended that the VISN Director ensure that the System Director requires that designated staff maintain current BLS and/or ACLS certification, in accordance with local policy.

The VISN and System Directors agreed with the CAP review findings and recommendation. They reported that training has been scheduled and that an electronic notification system was developed to support efforts to maintain accurate training records. 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 selected medication management processes in the acute inpatient medical and surgical units, the telemetry and medicine units, the medical and surgical intensive care units, the mental health inpatient unit, and the domiciliary. We found adequate management of medications brought into the facility by patients or families. We observed appropriate use of Bar Code Medication Administration to correctly identify patients prior to medication administration, and we found that reconciliation of CS discrepancies at the unit level was adequate. Additionally, we determined that self-medication administrations were completed safely and accurately. However, we identified one area that needed improvement.

Assessment of Pain Medication. The JC requires that the system develop criteria for pain assessment and follow-up. The system did not define a specific timeframe for assessing PRN (as needed) pain medication effectiveness. We reviewed 81 administered doses of PRN pain medications and found that the times between medication administration and documentation of patient response ranged from 1 minute to 376 minutes. Without appropriate follow-up, clinicians could not be assured that patients' pain was effectively managed.

Recommendation 8 We recommended that the VISN Director ensure that the System Director requires that local policy define a specific timeframe for assessing PRN pain medication effectiveness and that responses are documented in a timely manner.

The VISN and System Directors agreed with the CAP review findings and recommendation. They reported that local policy has been updated to include specific intervals for documentation of PRN pain medication effectiveness. The system will conduct monthly monitoring for documentation within the appropriate intervals. A compliance rate of above 90 percent will be considered satisfactory. The improvement

plan is acceptable, and we will follow up on the completion of the planned actions.

Review Activities Without Recommendations

Coordination of Care

The purpose of this review was to evaluate whether inpatient consultations, intra-facility (ward-to-ward) transfers, and discharges were coordinated appropriately over the continuum of care and met local, VHA, and JC requirements. Coordinated consultations, transfers, and discharges are essential to an integrated, ongoing care process resulting in optimal patient outcomes.

We reviewed the medical records of 15 inpatients who had consults ordered and performed internally. In general, we found that inpatients received consultative services within acceptable timeframes.

We determined that clinicians appropriately managed 15 (100 percent) of 15 intra-facility transfers. We found transfer notes from sending units to receiving units and documentation that nursing assessments were performed by the receiving units in accordance with established timeframes.

We reviewed the medical records of 15 discharged patients and found that all patients received appropriate written discharge instructions. We also found documentation indicating that the patients understood the instructions. We made no recommendations.

Emergency/Urgent Care Operations

The purpose of this review was to evaluate whether VHA facility emergency/urgent care operations 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 system's emergency department (ED) and triage environments for cleanliness and safety.

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

We reviewed the medical records of seven patients who presented in the ED with acute mental health conditions and found that all seven patients were managed appropriately. In addition, we determined that patient transfers complied with applicable policy.

We reviewed the ED 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 nursing competencies. We made no recommendations.

Staffing

The purpose of this review was to evaluate whether VHA facilities had developed comprehensive nurse staffing guidelines and whether the guidelines had been met. We reviewed nurse staffing documents for all inpatient units, including the intensive care units, and we interviewed nurse managers. We found the staffing methodology to be appropriate. We made no recommendations.

Survey of Healthcare Experiences of Patients

The purpose of this review was to assess the extent that VHA facilities 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 PM target results for patients reporting overall satisfaction of "very good" or "excellent" at 76 percent for inpatients and 77 percent for outpatients. Facilities are expected to address areas that fall below target scores. Figures 1 and 2 on the next page show the system's SHEP PM results for inpatients and outpatients, respectively.

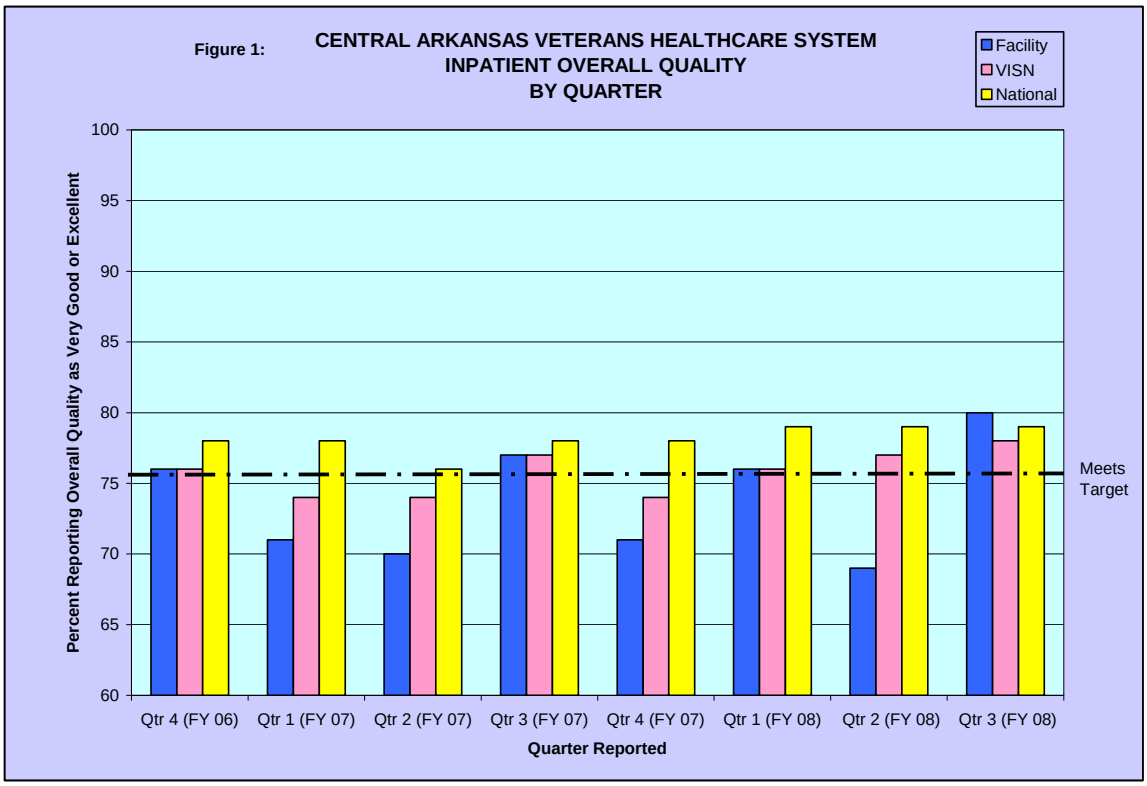
Figure 1:
CENTRAL ARKANSAS VETERANS HEALTHCARE SYSTEM
INPATIENT OVERALL QUALITY
BY QUARTER
Facility
VISN
National
Percent Reporting Overall Quality as Very Good or Excellent
100
95
90
85
80
75
70
65
60
Meets Target
Qtr 4 (FY 06)
Qtr 1 (FY 07)
Qtr 2 (FY 07)
Qtr 3 (FY 07)
Qtr 4 (FY 07)
Qtr 1 (FY 08)
Qtr 2 (FY 08)
Qtr 3 (FY 08)
Quarter Reported

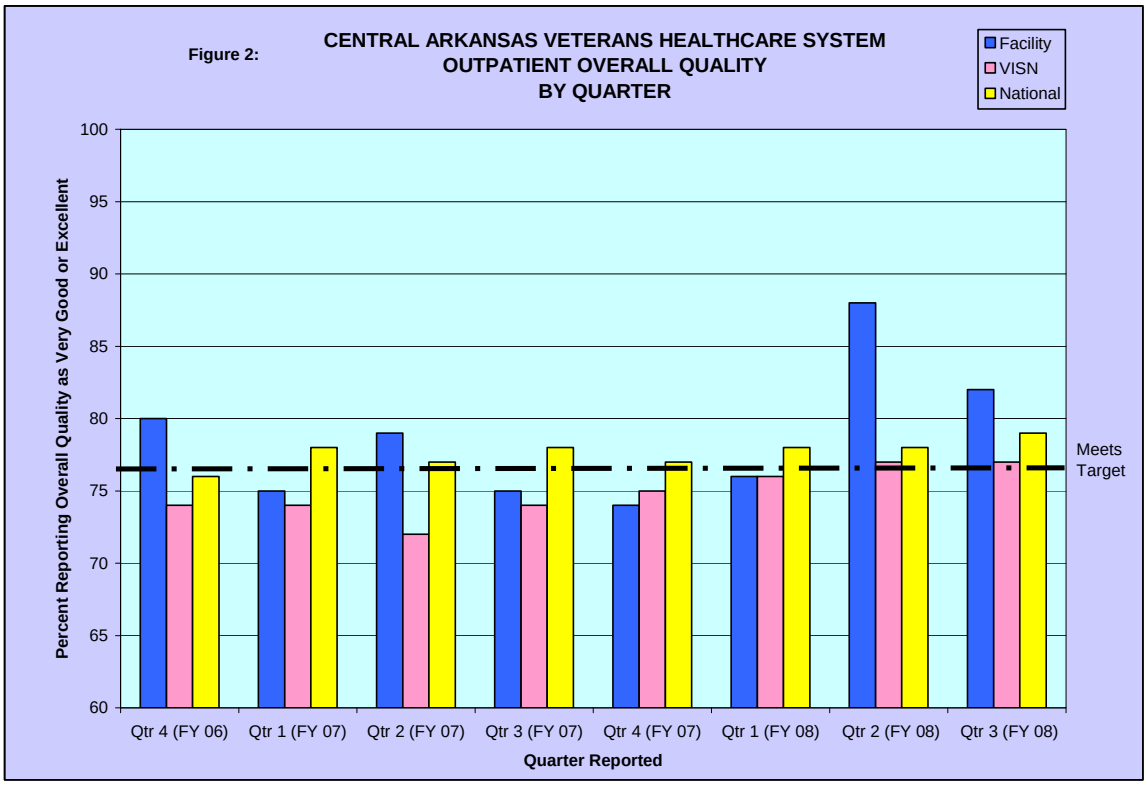
Figure 2:
CENTRAL ARKANSAS VETERANS HEALTHCARE SYSTEM
OUTPATIENT OVERALL QUALITY
BY QUARTER
Facility
VISN
National
Percent Reporting Overall Quality as Very Good or Excellent
100
95
90
85
80
75
70
65
60
Meets Target
Qtr 4 (FY 06)
Qtr 1 (FY 07)
Qtr 2 (FY 07)
Qtr 3 (FY 07)
Qtr 4 (FY 07)
Qtr 1 (FY 08)
Qtr 2 (FY 08)
Qtr 3 (FY 08)
Quarter Reported

The system did not meet the established target for 4 of the last 8 quarters of available data for both inpatient and outpatient overall satisfaction. However, managers had identified opportunities for improvement based on the SHEP survey scores and had developed action plans targeting specific services and departments. The action plans have been implemented, and there is evidence of ongoing activities and evaluation of the plan for effectiveness. Therefore, we made no recommendations.

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: December 23, 2008

From: Director, South Central VA Health Care Network (10N16)

Subject: **Combined Assessment Program Review of the Central Arkansas Veterans Healthcare System, Little Rock, AR**

To: Director, Dallas Healthcare Inspections Division (54DA)

Director, Management Review Service (10B5)

1. The CAP Report for Central Arkansas Veterans Healthcare System (CAVHS) has been reviewed. Hospital leadership is in concurrence with the report, and recommendations have been addressed with corrective action.

2. If you have further questions, please contact Dr. Kaleem Sayyed, Chief, Quality & Performance Service, CAVHS, at 501-257-5314.

(original signed by:)

George H. Gray, Jr.

System Director Comments

Department of Veterans Affairs **Memorandum**

Date: December 22, 2008

From: Director, Central Arkansas VA Veterans Healthcare System (598/00)

Subject: **Combined Assessment Program Review of the Central Arkansas Veterans Healthcare System, Little Rock, AR**

To: Director, South Central VA Health Care Network (10N16)

I concur with the finding/recommendations presented in the OIG CAP review of the Central Arkansas Veterans Healthcare System. Actions taken as a result of the findings can be found in the following pages below.

(original signed by:)

Michael R. Winn

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 System Director requires that suicide prevention posters and brochures are displayed in highly visible areas throughout the system.

Concur

- The VISN and Medical Center Directors agreed with the CAP review findings and recommendation and provided an acceptable improvement plan. The Director reported that during the OIG visit suicide prevention posters were placed in the emergency room, the atria waiting rooms, Primary Care, CBOCs, and all facility waiting areas and unit entry points at both campuses.

CORRECTIVE ACTION

- During the OIG visit suicide prevention posters were placed in the emergency room, the atria waiting rooms, Primary Care, CBOCs, and all facility waiting areas and unit entry points at both campuses.

Recommend that this action be closed.

Recommendation 2. We recommended that the VISN Director ensure that the System Director requires that EOC PMs meet VHA standards.

Concur

CORRECTIVE ACTION

- As of December 11, 2008, on a daily basis, the Safety Program Assistant and Safety Program Clerk are identifying any Environment Assessment Team (EAT) deficiencies that are 10 days old through the Open Deficiencies report in the EAT program.

- If there are deficiencies identified through the Open Deficiencies report Service Chief will be contacted by the Safety Program Assistant and/or Safety Program Clerk to remind them to get deficiencies corrected within 3 days or initiate a plan of action to

correct the deficiencies. If there are unresolved issues after the reminder, those issues will be forwarded to the Associate Medical Center Director or designee for resolution. All current deficiencies that are over 14 days old and do not require project funding will be corrected/abated by January 9, 2009.

Recommendation 3. We recommended that the VISN Director ensure that the System Director requires that local policy clearly designate responsibility for monitoring and maintaining the WanderGuard® system and that compliance is ensured.

Concur

CORRECTIVE ACTION

- The process of monitoring of patients using Wanderguard® system is currently in place and documented. Service wide plan for Wanderguard System has been developed and will be completed by January 16, 2009, and will include the following components:

    - Daily checks of all Wanderguards in patient use with portable Wanderguard tester.
    - Daily check of door sensors
    - Monthly reports will be forwarded through Nursing Performance Improvement starting January 2009.
    - Review of policy for missing patients will be completed by all relevant units by February 28, 2009.

Recommendation 4. We recommended that the VISN Director ensure that the System Director requires that all responsibilities of the CS Coordinator are incorporated into the local policy.

Concur

CORRECTIVE ACTION

- Local policy has been revised to document the changes which were made during the OIG visit and discussed with the inspector.

Recommend this action be closed.

Recommendation 5. We recommended that the VISN Director ensure that the System Director requires that the vault in North Little Rock outpatient pharmacy is in compliance with VA standards and guidelines.

Concur

CORRECTIVE ACTION

- The North Little Rock outpatient pharmacy vault enclosure will be built by an outside contractor and completed by February 1, 2009. CAVHS Engineering service will perform the finishing work. As required by the regulations, a concrete walled Type II vault will be constructed and incorporate a General Services Administration Class 5 vault door.

Recommendation 6. We recommended that the VISN Director ensure that the System Director requires that provider PI data are collected, analyzed, reviewed, considered as part of the reprivileging process, and recorded in PSB minutes.

Concur

CORRECTIVE ACTION

- A policy template was developed and distributed to all clinical service chiefs on November 7, 2008. The clinical service chiefs have presented their provider specific quality data and presented at the Medical Executive Board and Professional Standards Board, both held on December 9, 2008.

- The policy required the clinical service chief to conduct and define the following:
  i) The Focused Professional Practice Evaluations (FPPE) for new clinical staff during their first 6 months of practice (Full-time, Part-time, and WOC)
  ii) Ongoing Professional Practice Evaluations (OPPE) for existing providers that are reviewed, by the service chief, at least quarterly and formally discussed with the provider on at least a semi-annual basis.
  iii) Define evaluation for provider specific quality data in the following areas:
    a. FPPE
    b. OPPE
    c. Activity/Utilization (for procedure based practices)
    d. number of procedures performed by each of the requesting providers [e.g., Number of cardiac catheterizations by Interventional Cardiology]
    e. Continuing Medical Education
    f. Interpersonal Relationships and Communication Skills
    g. Professionalism and Citizenship – Compliance with Rules and Regulations
    h. Clinical Quality – General
    i. Clinical Quality – Specialty

j. Resource

iv) All service chiefs will be required to discuss the results of their FPPE and OPPE reviews at the Professional Standard Board on at least a semi-annual basis/annual basis respectively for all their clinical staff.

Recommendation 7. We recommended that the VISN Director ensure that the System Director requires that designated staff maintain current BLS and/or ACLS certification, in accordance with local policy.

Concur

CORRECTIVE ACTION

- All services having employees who need current BLS and/or ACLS certification were identified in November 2008. A review of 110 records identified 5 with out of date ACLS certification. The providers were offered training on December 12th 2008. Two have completed it, one is in the process. The other two providers are scheduled for the January/February 2009 ACLS training. The spring 2009 ACLS schedule, already posted in My Peak, was distributed via e-mail to all service chiefs.

- The comprehensive list of staff needing BLS renewals in 2009 is being compiled and will be distributed to all chiefs, etc., by January 1, 2009. In the interim, additional BLS courses have been scheduled at the unit/service level, with two centralized BLS renewal blitzes scheduled for January and February 2009; these are expected to continue system-wide on a quarterly basis.

- An electronic notification system was developed in order to support the clinical services' efforts in maintaining accurate training records as required by CAVHS.

Recommendation 8. We recommended that the VISN Director ensure that the System Director requires that local policy define a specific timeframe for assessing PRN pain medication effectiveness and that responses are documented in a timely manner.

Concur

CORRECTIVE ACTION

- Local policy has been updated to include specific intervals for documentation of pain medication effectiveness and is being piloted by nursing service. Re-education for all members of the interdisciplinary team regarding the hospital policy has been

conducted. Pain screening can be completed by any member of the interdisciplinary team with an in depth assessment to be completed by the RN or appropriate provider when indicated was emphasized. Assistance from Pain Management Oversight Committee regarding communication/education/monitoring to all appropriate services is also being sought.

- Monthly monitoring of a random week for PRN pain medication will be conducted for documentation of effectiveness within the appropriate intervals. A compliance rate over 90% will be considered satisfactory for compliance with PRN pain effectiveness.

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