Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 08-03074-101

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

March 31, 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 Lexington VA Medical Center (the medical center), Lexington, KY. 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 91 medical center employees. The medical center is part of Veterans Integrated Service Network (VISN) 9.

Results of the Review

The CAP review covered eight operational activities. We made recommendations in four of the activities reviewed. For these activities, the medical center needed to require that:

- Root cause analysis (RCA) actions be monitored, measurable, and evaluated for effectiveness.
- Data on resuscitation events and outcomes be discussed, analyzed, and compared over time to identify opportunities for improvement.
- Medical record reviews be completed in accordance with Veterans Health Administration (VHA) policy and that deficiencies be addressed.
- Performance improvement (PI) data is collected, analyzed, and used to support decisions during the reprivileging process.
- Discharge instructions, discharge summaries, and physician orders be consistent.
- All inter-facility transfer documentation complies with VHA policy.
- A system be developed to assure that all emergency department (ED) nursing staff competencies are completed and documented annually.
- Nurses consistently document the effectiveness of all pain medications within the timeframe established by local policy.

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

- Environment of Care (EOC).

- Pharmacy Operations.
- Staffing.
- Survey of Healthcare Experiences of Patients (SHEP).

This report was prepared under the direction of Victoria Coates, Director, Atlanta Office of Healthcare Inspections.

Comments

The VISN and Medical Center 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 medical center is a two-division (Cooper and Leestown) tertiary care facility located in Lexington, KY, that provides a broad range of inpatient and outpatient health care services. Outpatient care is also provided at four community based outpatient clinics (CBOCs) in Somerset, Morehead, Hazard, and Berea, KY. The medical center is part of VISN 9 and serves a veteran population of about 92,000 throughout 37 counties in central and eastern Kentucky.

Programs. The medical center provides medical, surgical, mental health, rehabilitation, and community living center (CLC)[1] services. It has 99 hospital beds and 61 CLC beds and operates several regional referral programs, including residential rehabilitation treatment programs for both post-traumatic stress disorder and substance abuse. The medical center also serves as the Polytrauma Network Site for VISN 9.

Affiliations and Research. The medical center is affiliated with the University of Kentucky and with 31 other colleges and universities. It provides training for 84 medical residents, as well as other disciplines, including nursing, respiratory therapy, psychology, pharmacy, health administration, optometry, social work, and dietetics. In fiscal year (FY) 2008, the medical center research program had 95 projects and a budget of $4 million. Important areas of research included thyroid and prostate cancer and type 2 diabetes.

Resources. In FY 2008, medical care expenditures totaled approximately $256.8 million. The FY 2009 medical care budget is approximately $225.7 million. FY 2008 staffing was 1,612 full-time employee equivalents (FTE), including 95 physician and 336 nursing FTE.

Workload. In FY 2008, the medical center treated 33,675 unique patients and provided 28,144 inpatient days in the hospital and 18,221 inpatient days in the CLC. The inpatient workload totaled 5,914 discharges, and the average

[1] A CLC (formerly called a nursing home care unit) provides a homelike environment to eligible veterans who require a nursing home level of care.

daily census, including CLC patients, was 127. Outpatient workload totaled 351,801 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:

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

The review covered medical center operations for FY 2007, FY 2008, and FY 2009 through November 7, 2008, and was done in accordance with OIG standard operating procedures for CAP reviews. We followed up on select recommendations from our prior CAP review of the medical center (*Combined Assessment Program Review of the*

VA Medical Center, Lexington, Kentucky, Report No. 06-00012-49, January 5, 2006). The medical center had corrected all findings related to health care from our prior CAP review.

We also followed up on recommendations from a report by VHA's Office of the Medical Inspector (OMI) (*Final Report: Quality of Care Review of the Delivery of Surgical Care, Lexington, Kentucky,* August 27, 2008.) In that report, the OMI made recommendations to improve documentation of physician involvement and decision making in surgical care, improve meeting minutes associated with surgical care, and ensure that providers receive due process in credentialing and privileging (C&P) actions. We reviewed the medical center's follow-up documentation and plans in response to the OMI recommendations. We found the medical center's actions to be appropriate, and we consider the OMI recommendations closed.

During this review, we also presented fraud and integrity awareness briefings to 91 employees. These briefings covered procedures for reporting suspected criminal activity to the OIG and included case-specific examples illustrating procurement fraud, conflicts of interest, and bribery.

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 findings requiring corrective actions.

Results

Review Activities With Recommendations

Quality Management Program

The purpose of this review was to evaluate whether the medical center had a comprehensive QM program designed to monitor patient care quality and whether senior managers actively supported the program's activities. We evaluated policies, PI data, and other relevant documents, and we interviewed appropriate senior managers and the QM Coordinator.

The 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. Appropriate review structures were in place for 11 of the 15 program activities reviewed. However, we identified four areas that needed improvement.

Root Cause Analysis. We found that elements of the RCA process did not comply with VHA guidelines. RCAs are designed to identify and resolve the root cause of system and/or process deficiencies involved in an actual or potential adverse event. VHA policy[2] requires that corrective actions be evaluated for effectiveness and that outcomes be measurable. This approach allows managers to assess whether the actions had the desired effect in improving, controlling, or eliminating the root cause of the condition.

The medical center completed a total of 10 RCAs (individual and aggregate) between October 2007 and September 2008. In these 10 RCAs, there were 21 issues identified that required corrective actions. We found that in 18 (86 percent) of the 21 issues, corrective actions were not monitored for effectiveness, and outcome measures were either not measurable or were not documented at all. For example, one corrective action included training mental health staff on the utilization of the Rapid Response Team. Although training was completed, the outcome measure of staff knowledge was not assessed. Without evaluation of corrective actions and documentation of outcome measures, managers could not determine whether the expected outcomes were achieved and the root causes were addressed.

Resuscitation Outcome Analysis. We found that the Critical Care Committee did not discuss cardiopulmonary resuscitation (CPR) events and their outcomes. CPR is a life-saving process for patients who suffer a cardiac arrest. External accreditation standards require that data on resuscitation events and outcomes be aggregated, analyzed, and compared over time (either internally or externally) to identify opportunities for improvement.

To obtain appropriate benchmark data, the medical center submits data to the National Registry of CardioPulmonary Resuscitation (NRCPR) on all of its CPR events. The NRCPR then provides quarterly reports, including benchmark data, back to the medical center. Despite the availability of data, the Critical Care Committee did not discuss, analyze, or compare CPR data over time to identify existing trends or

[2] VHA Handbook 1050.01, *VHA National Patient Safety Improvement Handbook*, May 23, 2008.

potential problems. Without analysis, managers could not be assured that CPR was performed correctly and timely and that problems were addressed.

Medical Record Reviews. We found that services did not regularly conduct medical record reviews to monitor appropriate documentation, as required by VHA policy.[3] In addition, results of reviews conducted were not reported to the Medical Records Committee (MRC). VHA policy requires ongoing medical record reviews to assess the quality, consistency, accuracy, completeness, and authentication[4] of medical record entries. Results of record reviews, findings from record completion monitors, and delinquent record statistics must be reported to the MRC. Without this information, the committee could not aggregate data, identify variances, and make recommendations for improvement in the documentation of patient care.

In FY 2008, the MRC identified 57 percent of physician orders and 25 percent of progress notes as delinquent.[5] This information was not forwarded to the Medical Staff Committee, and we found no evidence that corrective actions were taken. Without complete medical record entries, managers could not be assured that relevant patient care and treatment information was available to clinicians.

Provider Performance Monitoring. VHA regulations[6] require that clinical managers develop plans for continuous performance monitoring of the medical staff. According to requirements, collection of individual performance data should be ongoing, include indicators for continuing qualifications and competencies, and be reviewed and considered during the reprivileging process. At the time of our review, we found that clinical leaders had completed the C&P training modules and had developed plans for ongoing physician competency monitoring. However, we found that for providers reprivileged in the past 12 months, 24 (80 percent) of the 30 C&P folders did not contain adequate performance and corresponding PI data to support the privileges granted. Without adequate evaluation of provider performance, managers could not be assured that clinical interventions met standards of practice.

[3] VHA Handbook 1907.01, *Health Information Management and Health Records*, August 25, 2006.
[4] Authenticated entries include the date and time and the signature of practitioner.
[5] Delinquent entries have not been authenticated and have failed to meet timeliness standards.
[6] VHA Handbook 1100.19, *Credentialing and Privileging*, October 2, 2007.

Recommendation 1 We recommended that the VISN Director ensure that the Medical Center Director requires that RCA actions be monitored, measurable, and evaluated for effectiveness.

The VISN and Medical Center Directors agreed with the findings and recommendation. The medical center developed an internal process to ensure that RCA actions are strong and that outcome measures are quantifiable. This will allow managers to evaluate effectiveness. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

Recommendation 2 We recommended that the VISN Director ensure that the Medical Center Director requires that data on resuscitation events and outcomes be discussed, analyzed, and compared over time to identify opportunities for improvement.

The VISN and Medical Center Directors agreed with the findings and recommendation. A critical care nurse specialist is now responsible for maintaining the NRCPR database and providing monthly reports to the Critical Care Committee. Oversight of the Critical Care Committee is now assigned to the Clinical Executive Council, which is chaired by the Chief of Staff. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

Recommendation 3 We recommended that the VISN Director ensure that the Medical Center Director requires that medical record reviews be completed in accordance with VHA policy and that deficiencies be addressed.

The VISN and Medical Center Directors agreed with the findings and recommendation. The medical center is developing reporting matrices to summarize all ongoing point-of-care and medical record reviews. The medical record review matrix will include timeliness of progress note and order signatures. Point-of-care and medical record reviews are being added to the MRC agenda template as monthly recurring report items. Findings, actions, and recommendations will also be reviewed and/or addressed by the Clinical Executive Council. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

Recommendation 4 We recommended that the VISN Director ensure that the Medical Center Director requires that provider PI data is

collected, analyzed, and used to support decisions during the reprivileging process.

The VISN and Medical Center Directors agreed with the findings and recommendation. The medical center is developing standardized, provider-specific report cards that will be used by all services for reprivileging decisions. In addition, the medical center revised the Professional Standards Board meeting minutes template to include ongoing practice evaluation information. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

Coordination of Care

The purpose of this review was to evaluate whether selected aspects of care, such as consultations, intra-facility transfers, and discharges, were coordinated appropriately over the continuum of care. Timely responses to consultations, effective management of patient transfers, and appropriate discharge instructions are essential to optimal patient outcomes.

We reviewed randomly selected records for the 4th quarter of FY 2008. We found timely responses for all 12 of the inpatient consultations we reviewed, and in all cases, nursing assessments had been completed within the required timeframes. In addition, we reviewed medical records of patients who transferred between units. In 11 (92 percent) of the 12 records reviewed, we found consistent and timely patient assessments by receiving unit nursing staff. We identified one area that needed improvement.

Discharge Documentation. We found that medical record discharge documentation was inconsistent. There were inconsistencies between patient discharge instructions, discharge summaries, and physician orders in 7 (58 percent) of the 12 medical records we reviewed. In all seven records, the nursing discharge instruction sheet templates listed some medications that had been discontinued at the time of discharge. Two of these records also contained incorrect discharge diet orders. Additionally, we found that 5 (42 percent) of the 12 records had medication inconsistencies between patient discharge summaries and physician orders. Without consistency in discharge documentation, patient safety can be at risk. Conflicting instructions could be confusing to patients and other care

providers and increase the probability of non-compliance or an adverse event.

We noted that the medical center had recently expanded the medication reconciliation program to include reconciliation at discharge with a pharmacist providing bedside discharge counseling and education. This process is aimed at lowering the percentage of unreconciled medications.

Recommendation 5 We recommended that the VISN Director ensure that the Medical Center Director requires that discharge instructions, discharge summaries, and physician orders be consistent.

The VISN and Medical Center Directors agreed with the findings and recommendation. The medical center is developing a standardized pharmacy note template, which will include key regulatory requirements. This note will be printed and given to the patient prior to discharge. In addition, to ensure consistent discharge medication information, medication lists will no longer be imported into discharge summaries or discharge nursing notes. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

Emergency/Urgent Care Operations

The purpose of this review was to evaluate selected aspects of the ED, such as clinical services, consultations, inter-facility transfers, staffing, and staff competencies.

We interviewed ED physicians, the ED program manager, and other Critical Care Service Line staff. We reviewed policies and other pertinent documents, including competency files and C&P folders. We also reviewed selected medical records of patients who had consultations to other services and who were transferred from the ED to other medical facilities.

The ED is located in the main hospital building at the Cooper division and is open 24 hours per day, 7 days per week, as required for an ED. Emergency services provided are within the medical center's patient care capabilities. Also, the medical center has a procedure in place for the management of patients whose care may exceed the medical center's capability.

We conducted EOC tours and found that the environment was clean and safe and that equipment was appropriately

maintained. However, we identified the following conditions that needed improvement:

Inter-Facility Transfers. Patient transfer documentation did not consistently comply with VHA policy.[7] We reviewed the medical records of three patients who were transferred to other facilities. We were unable to find transfer orders or evidence of physician-to-physician handoff communication for any of the three patients. Without proper documentation, managers could not be assured that continuity of patient care had been achieved.

Emergency Department Nurse Competency Assessments. We found completed unit-based competency assessments for FY 2008 for three randomly selected nursing files we reviewed; however, we were unable to find competency evaluations for FYs 2005, 2006, and 2007. Medical center policy requires that nurse competencies be completed annually. Without competency assessments, medical center managers could not be assured that ED nurses had the skills necessary to safely and appropriately perform patient care activities.

Recommendation 6 We recommended that the VISN Director ensure that the Medical Center Director requires that all inter-facility transfer documentation comply with VHA policy.

The VISN and Medical Center Directors agreed with the findings and recommendation. The medical center implemented a process to ensure that inter-facility transfer documentation is completed, as required. The process is being monitored, data is being aggregated, and findings will be reported to the Clinical Executive Council. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

Recommendation 7 We recommended that the VISN Director ensure that the Medical Center Director develops a system to assure that all ED nursing staff competencies are evaluated and documented annually.

The VISN and Medical Center Directors agreed with the finding and recommendation. The medical center has changed the process for filing nurse competencies. Copies of competencies are now retained by responsible nurse

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

managers, attached to annual proficiency reports, and filed in the official personnel records. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

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 on the inpatient acute medical/surgical, mental health, and intensive care units. 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. Also, we found that reconciliation of controlled substances discrepancies at the unit level was adequate. We identified one area that needed improvement.

Documentation of Pain Medication Effectiveness. We found that documentation of pain medication effectiveness did not comply with local policy. We reviewed 18 administered doses of PRN (as needed) pain medication. We found effectiveness documented within 1 hour, as required by local policy, for only four (22 percent) of the doses. For the remaining doses, the times between medication administration and the evaluation of effectiveness ranged from 139 to 434 minutes. Without appropriate follow-up and consistent documentation, clinicians could not be assured that patients' pain was effectively managed.

Recommendation 8 We recommended that the VISN Director ensure that the Medical Center Director requires that nurses consistently document the effectiveness of all pain medications within the timeframe established by local policy.

The VISN and Medical Center Directors agreed with the findings and recommendation. The medical center implemented an automated monitoring approach for PRN effectiveness documentation. Feedback is provided to unit managers and staff nurses weekly. Aggregated data and results will be reported to the Clinical Executive Council for review, discussion, and action, as appropriate. The

implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

Review Activities Without Recommendations

Environment of Care

The purpose of this review was to determine whether the medical center maintained a safe and clean health care environment. Medical centers are required to provide a comprehensive EOC program that fully meets VHA, Occupational Safety and Health Administration, and external accreditation standards.

We inspected the locked mental health unit (4S), the CLC, an acute care unit (3S), the progressive care unit, and the intensive care unit. The medical center maintained a generally clean and safe environment. Infection control program staff monitored and reported data to clinicians for implementation of quality improvements. Safety guidelines were met, and risk assessments complied with VHA standards. Furthermore, managers on the locked mental health unit complied with safety regulations, and staff were trained to identify environmental hazards.

During our tour, we found that suicide prevention posters were not consistently displayed in designated high-visibility areas, dirty linen hampers were stored in a hydrotherapy room on unit 3S, and nurse call buttons located in patient rooms on 4S were inoperable. Because managers took immediate actions to address these deficiencies while we were onsite, we made no recommendations.

Pharmacy Operations

The purpose of this review was to evaluate whether VHA facilities had adequate controls to ensure the security and proper management of controlled substances and the safety and security of the inpatient and outpatient pharmacies' internal physical environments. We also assessed whether clinical managers had processes in place to monitor patients for polypharmacy.

We evaluated whether the medical center's policies and practices were consistent with VHA regulations[8] governing pharmacy and controlled substances security. We inspected inpatient and outpatient pharmacies for security, EOC, and

[8] 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.

infection control issues. We interviewed appropriate Pharmacy Service staff and Police and Security Service personnel.

Pharmacy Controls. The medical center had appropriate policies and procedures to ensure the security of controlled substances and to ensure the safety and security of the pharmacies' physical environments. Training records showed that the Controlled Substances Coordinator and controlled substances inspectors received appropriate training to execute their duties. We found that the pharmacies were secure, clean, and well maintained.

Polypharmacy. Pharmacological regimens involving multiple medications are often necessary to prevent and control disease states; however, excessive use of medications can result in adverse reactions and increased risk 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.[9]

We interviewed pharmacy clinical managers to determine the medical center's efforts to monitor and avoid inappropriate polypharmacy. Clinical pharmacists identified patients who were prescribed multiple medications, reviewed the medication regimens to avoid complications related to polypharmacy, and advised providers regarding potential polypharmacy complications when appropriate. 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 and actual staffing for the ED, an acute care unit, the intensive care unit, and the CLC. We found that guidelines were met and that specific actions had been taken to ensure patient safety, including

[9] Yvette C. Terrie, BSPharm, RPh, "Understanding and Managing Polypharmacy in the Elderly," *Pharmacy Times*, December 2004.

cross-coverage by staff and the use of a nurse registry. We made no recommendations.

Survey of Healthcare Experiences of Patients

The purpose of this review was to assess the extent that VHA facilities use SHEP data to improve patient care, treatment, and services. The SHEP program is aimed at capturing patient perceptions of care in 12 service areas, including access to care, coordination of care, and courtesy. VHA relies on the Office of Quality and Performance's analysis of the survey data to improve the quality of care delivered to patients. VHA's Executive Career Field Performance Plan states that at least 76 percent of inpatients discharged during a specified date range and 77 percent of outpatients treated will report the overall quality of their experiences as "very good" or "excellent." Facilities are expected to address areas in which they are underperforming.

The graphs shown below and on the next page show the medical center's performance in relation to national and VISN performance. Figure 1 shows the medical center's SHEP performance measure results for inpatients, and Figure 2 shows the medical center's SHEP performance measure results for outpatients.

Figure 1:

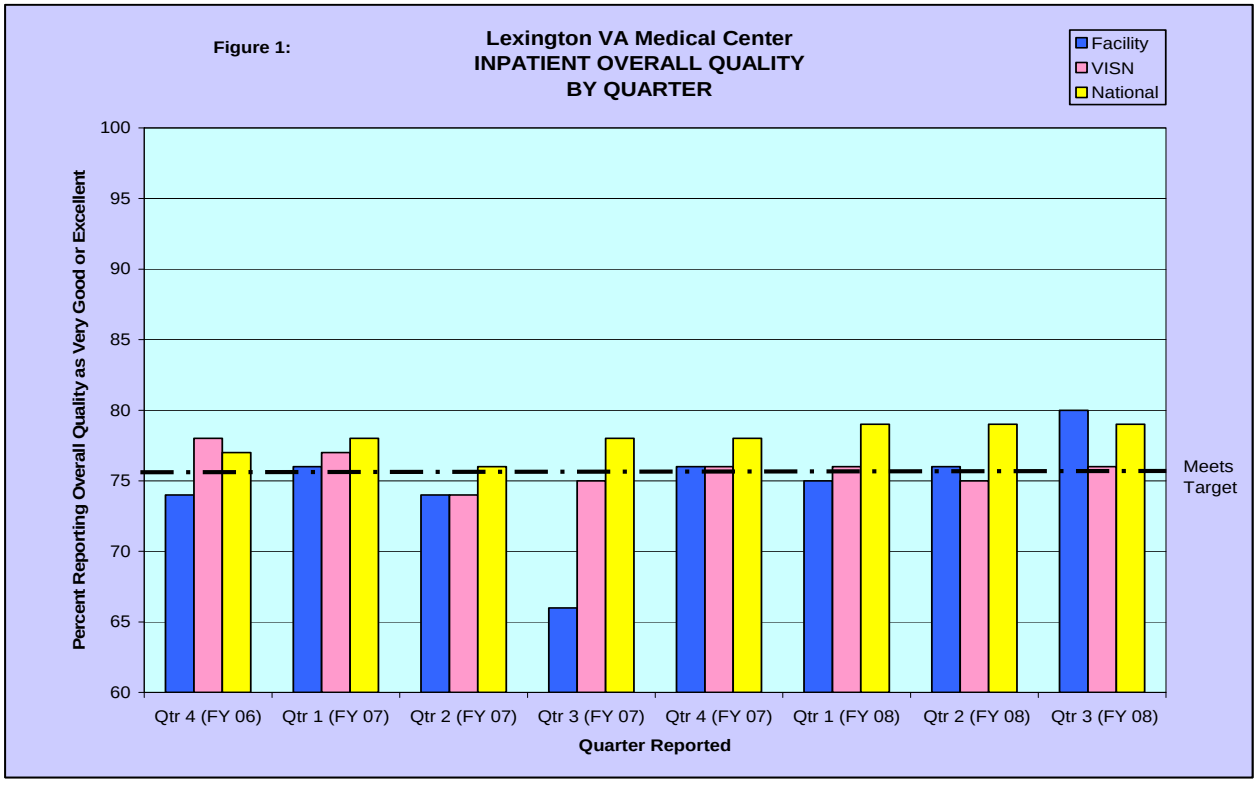
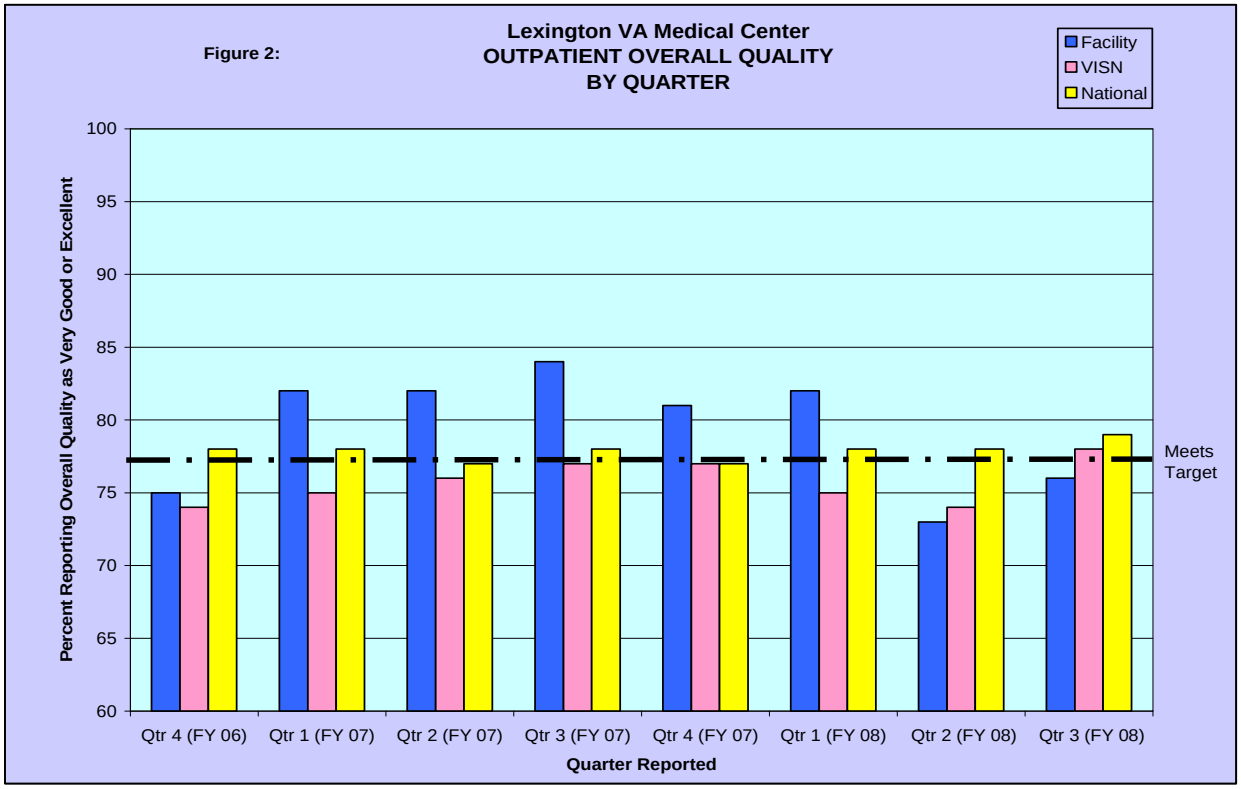


Figure 2:



The medical center met or exceeded the established target for inpatient overall quality in 4 of the last 8 quarters and met or exceeded the target for outpatient overall quality in 5 of the last 8 quarters.

The medical center had a multidisciplinary Patient Satisfaction Committee that analyzed and reported SHEP survey results. Managers had initiated improvement actions, which included creating a Pharmacy call center, initiating service recovery, providing Disney Institute training, and implementing other goal sharing activities. The medical center's improvement plan, corrective actions, and recent internal patient satisfaction scores demonstrated positive impact; therefore, we made no recommendations.

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: February 18, 2009

From: Network Director (10N9), VA Mid South Healthcare Network

Subject: **Combined Assessment Program Review of the Lexington VA Medical Center, Lexington, Kentucky**

To: Director, Atlanta Office of Healthcare Inspections (54AT)

Director, Management Review Service (10B5)

1. I concur with the findings and recommendations of this Office of Inspector General Combined Assessment Program Review of the Lexington VA Medical Center as well as the action plan developed by the facility.

2. If you have questions or require additional information from the Network, please do not hesitate to contact Pamela Kelly, Staff Assistant to the Network Director, at 615-695-2205 or me at 615-695-2206.

(original signed by:)

John Dandridge, Jr.

Medical Center Director Comments

Department of Veterans Affairs **Memorandum**

Date: February 16, 2009

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

Subject: **Combined Assessment Program Review of the Lexington VA Medical Center, Lexington, Kentucky**

To: Director, VA Mid South Healthcare Network (10N9)

1. On behalf of the Lexington VA Medical Center, I concur with the findings and recommendations of this Office of Inspector General report. We had already been actively working to improve or enhance several of these areas and welcome the "fresh eyes" perspective provided by this report.

2. Included herein is an outline of improvement actions already taken, in progress, or planned in response to these findings. We believe these changes will further enhance key systems and processes in our medical center.

(original signed by:)

Sandy J. Nielsen, FACHE

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 RCA actions be monitored, measurable, and evaluated for effectiveness.

Concur

Lexington was one of 37 VA facilities to be recognized with bronze level RCA Cornerstone Recognition by the National Center for Patient Safety in 2008 and was already committed to achieving the gold level in 2009. Requirements for this include having strong RCA actions with quantifiable outcome measures. Our most recent RCA was critiqued by the National Center for Patient Safety (NCPS) with concurrence of strong action and quantifiable outcome. The root cause action and outcome submitted were:

- **Root Cause**: Lack of explicit assessment criteria defining elopement risks increased the likelihood that patients would not be properly assessed and closely monitored and increases the risk of patient elopements.

- **Action**: Standardize the missing patient assessment to include elements from the VHA directive (2008-057). This action will standardize and serve as documentation for the missing patient assessment.

- **Outcome**: A minimum of 5 chart reviews/month for a period of 4 months will show 100% completion of the wandering/missing patient assessment. Monthly random record review for 4 months: N = number of completed documented assessments; D = number of assessments reviewed. Threshold = 100%.

Target Completion Date: Complete/ongoing

Recommendation 2. We recommended that the VISN Director ensure that the Medical Center Director requires that data on resuscitation events and outcomes be discussed, analyzed, and compared over time to identify opportunities for improvement.

Concur

A recently hired surgical intensivist is now chairing the Critical Care Committee. In addition, we have added a new critical care nurse specialist who is responsible for maintaining the National Registry of CardioPulmonary Resuscitation (NRCPR) database and providing monthly reports to the Critical Care Committee. As of February 2009, this is a recurring monthly agenda item for the committee. The facility is also in the final stages of completely revamping its committee structure and charters to ensure appropriate functioning and oversight of all committee activities by a higher level Council, chaired by an accountable Quad member. Oversight of the Critical Care Committee is assigned to the Clinical Executive Council, chaired by the Chief of Staff. Findings, actions, and recommendations will also be reviewed and/or addressed by the Clinical Executive Council.

Target Completion Date: Complete/ongoing

Recommendation 3. We recommended that the VISN Director ensure that the Medical Center Director requires that medical record reviews be completed in accordance with VHA policy and that deficiencies be addressed.

Concur

Although there were point of care reviews being done, results were not being consistently reported to the Medical Records Committee. The Chief of Health Information Management (HIMS) is developing a reporting matrix to summarize all ongoing point of care reviews; the responsible individuals; and the schedule for reporting results to the Medical Record Committee. A similar matrix is also being developed for other ongoing medical record reviews, including timeliness of progress note and orders signatures to ensure these are routinely reported to the Committee for discussion and development of further actions as needed. The matrices will be presented to the Medical Records Committee not later than March. These two areas are being added to the Medical Records Committee agenda template as monthly recurring report item. Findings, actions, and recommendations will also be reviewed and/or addressed by the Clinical Executive Council.

Target Completion Date: March 31, 2009

Recommendation 4. We recommended that the VISN Director ensure that the Medical Center Director requires that provider PI data is collected, analyzed, and used to support decisions during the reprivileging process.

Concur

Key improvement actions were in progress at the time of the OIG visit including development of standardized provider-specific report cards using guidance from the VA Office of Quality and Performance and development of core privileges. These reports will be completed for all services by March 31, 2009, and will be consistently used for all re-privileging decisions after that date. Additional actions taken following the visit include revision of the Professional Standards Board minutes template to require comment on (1) plan for focused evaluation for new providers; (2) information considered in re-privileging recommendations (Ongoing Practice Evaluation Information).

Target Completion Date: March 31, 2009

Recommendation 5. We recommended that the VISN Director ensure that the Medical Center Director requires that discharge instructions, discharge summaries, and physician orders be consistent.

Concur

Clinical pharmacists have oversight responsibility for inpatient medication reconciliation and are developing a standardized note template which includes key regulatory requirements and which will be printed and given to the patient prior to discharge. Medication lists will no longer be imported as data objects into discharge summaries or discharge nursing notes to ensure there is no inconsistent discharge medication information. These notes will instead reference the new medication reconciliation discharge note. Medical Records staff will monitor this and will report results to the Medical Record Committee. Findings, actions, and recommendations will also be reviewed and/or addressed by the Clinical Executive Council.

Target Completion Date: March 31, 2009

Recommendation 6. We recommended that the VISN Director ensure that the Medical Center Director requires that all inter-facility transfer documentation comply with VHA policy.

Concur

At the time of this finding, the Emergency Room (ER) director instituted an immediate process change, requiring the ER physician and nursing staff to ensure there is a signed Interfacility Transfer form and consent for all patient transfers. The Administrative Officer of the Day (AOD) CPRS interfacility transfer note was also modified as a cross check to include validation that consent for transfer was available at the time of transfer. Health Administration Service (HAS) is monitoring transfer records to ensure that the required documentation is present and will provide immediate feedback of individual problems to the ER Director and

Transfer Coordinator. In addition, aggregate data re: compliance with inter-facility transfer documentation requirements will be reported to the Medical Records Committee as point of care reviews starting in March. Findings, actions, and recommendations will also be reviewed and/or addressed by the Clinical Executive Council.

Target Completion Date: Complete/ongoing

Recommendation 7. We recommended that the VISN Director ensure that the Medical Center Director develops a system to assure that all ED nursing staff competencies are evaluated and documented annually.

Concur

The system for processing and filing nursing competencies has been changed so that in addition to copies being retained by responsible nurse managers, a copy of each RN proficiency is also being attached to the annual proficiency report and kept on file in the Official Personnel Files.

Target Completion Date: Complete/ongoing

Recommendation 8. We recommended that the VISN Director ensure that the Medical Center Director requires that nurses consistently document the effectiveness of all pain medications within the timeframe established by local policy.

Concur

Patient Care Services implemented an automated monitoring approach for PRN effectiveness documentation in November with drill down at the individual nurse level. Feedback is provided to unit managers and individual staff nurses on a weekly basis. Documentation of effectiveness is at 98% for the most recent report period. Monitoring timeliness of the documentation has been a greater challenge because of limitations in the BCMA package. The availability of accurate data has been limited by BCMA itself, and a remedy ticket and enhancement requests have been made to the national office so that the nurses can accurately document the time they actually assessed the prn effectiveness, not the time the data was entered into the computer. In the interim, extensive teaching has been done and will continue to be done with unit staff as well as individual users to show them how to enter information in a way that shows when they actually assessed the effectiveness of the prn medication. Monitoring of timeliness with feedback to managers and individual nurses will continue until the local measure of success threshold is met. Aggregate results will also be submitted as point of care reviews to the Medical Records Committee starting in March. Findings, actions,

and recommendations will also be reviewed and/or addressed by the Clinical Executive Council.

Target Completion Date: March 31, 2009

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