Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 12-02185-288

Combined Assessment Program Review of the Tennessee Valley Healthcare System Nashville, Tennessee

September 27, 2012

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 crime awareness briefings 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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Glossary

CAP	Combined Assessment Program
COC	coordination of care
CRC	colorectal cancer
ED	emergency department
EHR	electronic health record
EOC	environment of care
facility	Tennessee Valley Healthcare System
FY	fiscal year
HF	heart failure
HPPD	hours per patient day
JC	Joint Commission
MH	mental health
MOD	Medical Officer of the Day
MSDS	material safety data sheet
OIG	Office of Inspector General
POCT	point-of-care testing
PR	peer review
QM	quality management
SCI	spinal cord injury
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

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Executive Summary: Combined Assessment Program Review of the Tennessee Valley Healthcare System, Nashville, TN

Review Purpose: The purpose was to evaluate selected activities, focusing on patient care administration and quality management, and to provide crime awareness training. We conducted the review the week of July 16, 2012.

Review Results: The review covered 10 activities. We made no recommendations in the following five activities:

- Colorectal Cancer Screening
- Coordination of Care
- Medication Management
- Mental Health Treatment Continuity
- Polytrauma

The facility's reported accomplishment was recognition through two U.S. Department of Health and Human Services awards for improvements in infection rates in the medical intensive care unit at the Nashville campus.

Recommendations: We made recommendations in the following five activities:

Environment of Care: Ensure that Environment of Care Board minutes reflect required elements and that oxygen tanks are properly secured and stored. Require that material safety data sheets inventory lists and hazardous material information binders are current and that eyewash stations are tested weekly. Properly seal the open wall penetration in the surgical unit. Conduct and document safety inspections on all ceiling lifts.

Moderate Sedation: Include all required elements in pre-sedation assessment documentation.

Quality Management: Ensure that Peer Review Committee quarterly reports to the Medical Executive Board include all required elements and that Medical Officers of the Day maintain Advanced Cardiac Life Support certification.

Point-of-Care Testing: Ensure that clinicians are consistently notified of critical test results requiring follow-up and that the required template is used for notification.

Nurse Staffing: Reassess unit 2N's and unit 1A's target nursing hours per patient day to more accurately plan for staffing and evaluate the actual staffing provided.

Comments

The Veterans Integrated Service Network and Facility Directors agreed with the Combined Assessment Program review findings and recommendations and provided acceptable improvement plans. We will follow up on the planned actions until they are completed.

JOHN D. DAIGH, JR., M.D.
Assistant Inspector General for
Healthcare Inspections

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 crime awareness briefings 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 selected areas, interviewed managers and employees, and reviewed clinical and administrative records. The review covered the following 10 activities:

- COC
- CRC Screening
- EOC
- Medication Management
- MH Treatment Continuity
- Moderate Sedation
- Nurse Staffing
- POCT
- Polytrauma
- QM

We have listed the general information reviewed for each of these activities. Some of the items listed might not have been applicable to this facility because of a difference in size, function, or frequency of occurrence.

The review covered facility operations for FY 2011 and FY 2012 through July 16, 2012, and was done in accordance with OIG standard operating procedures for CAP reviews. We also asked the facility to provide us with their current status on the recommendations we made in our previous CAP report (*Combined Assessment Program Review of the Tennessee Valley Healthcare System, Nashville, Tennessee,* Report No. 11-00030-160, May 5, 2011). We made repeat recommendations in EOC and QM.

During this review, we presented crime awareness briefings for 159 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.

Additionally, we surveyed employees regarding patient safety and quality of care at the facility. An electronic survey was made available to all facility employees, and 442 responded. We shared survey results with facility managers.

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.

Reported Accomplishment

U.S. Department of Health and Human Services Awards

The U.S. Department of Health and Human Services recognized the Nashville campus medical intensive care unit with two awards in 2011—Honorable Mention for Achievement in Eliminating Central Line[1] Associated Bloodstream Infections and Outstanding Achievement and Leadership Award on Eliminating Ventilator Associated Pneumonias. The facility was the first in VHA to be recognized and one of only two hospitals in the nation to receive two awards. Infection rates, the number of days central lines were in place, patient lengths of stay, and mortality rates steadily decreased, resulting in positive outcomes for patients and savings of more than $4 million annually.

[1] An indwelling intravenous catheter inserted through a large vein for the purposes of administering fluids and medications.

Results

Review Activities With Recommendations

EOC

The purpose of this review was to determine whether the facility maintained a safe and clean health care environment in accordance with applicable requirements

At the Nashville campus, we inspected the ED; the polytrauma and dental clinics; and the medical, surgical, medical cardiac care, and locked MH units. At the Murfreesboro campus, we inspected the medical, medical intensive care, hospice, and locked MH units; two community living centers; the gastroenterology laboratory; the ED; and the dental and outpatient SCI clinics. We also reviewed relevant documents and training records, and we interviewed key employees and managers. The areas marked as noncompliant in the table below needed improvement. Details regarding the findings follow the table.

Noncompliant	Areas Reviewed for General EOC
X	EOC Committee minutes reflected sufficient detail regarding identified deficiencies, progress toward resolution, and tracking of items to closure.
	Infection prevention risk assessment and committee minutes reflected identification of high-risk areas, analysis of surveillance activities and data, actions taken, and follow-up.
	Patient care areas were clean.
X	Fire safety requirements were met.
X	Environmental safety requirements were met.
	Infection prevention requirements were met.
	Medication safety and security requirements were met.
	Sensitive patient information was protected, and patient privacy requirements were met.
X	The facility complied with any additional elements required by local policy.
	Areas Reviewed for Dental EOC
	If lasers were used in the dental clinic, staff who performed or assisted with laser procedures received medical laser safety training, and laser safety requirements were met.
	General infection control practice requirements in the dental clinic were met.
	Dental clinic infection control process requirements were met.
	Dental clinic safety requirements were met.
	The facility complied with any additional elements required by local policy.
	Areas Reviewed for SCI EOC
X	EOC requirements specific to the SCI Center and/or outpatient clinic were met.
	SCI-specific training was provided to staff working in the SCI Center and/or SCI outpatient clinic.
	The facility complied with any additional elements required by local policy.

	Areas Reviewed for MH Residential Rehabilitation Treatment Program
	There was a policy that addressed safe medication management, contraband detection, and inspections.
	MH Residential Rehabilitation Treatment Program inspections were conducted, included all required elements, and were documented.
	Actions were initiated when deficiencies were identified in the residential environment.
	Access points had keyless entry and closed circuit television monitoring.
	Female veteran rooms and bathrooms in mixed gender units were equipped with keyless entry or door locks.
	The facility complied with any additional elements required by local policy.

EOC Board Activities. The JC requires that facilities monitor and analyze EOC issues and take action on identified deficiencies until resolved. In addition, local policy requires that EOC Board minutes include findings, data analysis reflecting trends, and actions taken. We reviewed EOC Board minutes from September of 2011 to April of 2012 and determined that the minutes did not consistently reflect required elements.

Environmental and Fire Safety. The Occupational Safety and Health Administration requires that portable oxygen tanks are stored upright and properly secured in a holder in a manner that distinguishes between empty and full tanks. On the medical and locked MH units at the Nashville campus, we found several unsecured portable oxygen tanks. On the hospice unit at the Murfreesboro campus, we found five empty oxygen tanks located in the holder designated for full tanks. This is a repeat finding from the previous CAP review.

The JC and the Occupational Safety and Health Administration require that facilities maintain current MSDS inventory lists and hazardous material information for chemicals used in clinical areas. Local policy requires that each service maintain at least one service-specific hard copy inventory list and hazardous material information binder. At the Nashville campus, we found that five of six MSDS binders were not current and that four staff members we asked were not able to access the electronic MSDS program. At the Murfreesboro campus, we found that 10 of 11 MSDS binders were not current; however, all five staff members we asked were able to access the electronic MSDS program.

VHA requires that emergency eyewash stations be activated weekly to flush the lines and ensure proper operation.[2] These weekly tests must be documented. At the Nashville campus, there was no documentation of testing of the emergency eyewash station in the ED.

The National Fire Protection Association requires that all wall penetrations be sealed to avoid fast spreading of flames and fumes during a fire. At the Nashville campus, we found an unsealed wall penetration in an information technology equipment room located on the surgical unit.

[2] VHA Directive 2009-026, *Location, Selection, Installation, Maintenance, and Testing of Emergency Eyewash and Shower Equipment,* May 13, 2009.

SCI Environmental Safety. VA requires that an inspection of each ceiling lift in the SCI outpatient clinic be completed after installation and documented on the After Installation Checklist.[3] At the Murfreesboro campus, there was no documentation that the ceiling lifts in the SCI outpatient clinic had been inspected.

Recommendations

1. We recommended that processes be strengthened to ensure that EOC Board minutes reflect required elements.

2. We recommended that processes be strengthened to ensure that oxygen tanks are properly secured and stored in a manner that distinguishes between empty and full tanks.

3. We recommended that processes be strengthened to ensure that MSDS inventory lists and hazardous material information binders are current and that staff are trained on how to access the electronic MSDS program.

4. We recommended that processes be strengthened to ensure that the emergency eyewash station in the Nashville campus ED is tested weekly and that this testing is documented.

5. We recommended that the open wall penetration in the surgical unit be properly sealed.

6. We recommended that processes be strengthened to ensure that safety inspections are conducted and documented on all ceiling lifts in the Murfreesboro campus SCI outpatient clinic.

[3] VA National Center for Patient Safety, "Ceiling mounted patient lift installations," Patient Safety Alert 10-07, March 22, 2010.

Moderate Sedation

The purpose of this review was to determine whether the facility had developed safe processes for the provision of moderate sedation that complied with applicable requirements.

We reviewed relevant documents, 12 EHRs, and 24 training/competency records, and we interviewed key employees. The area marked as noncompliant in the table below needed improvement. Details regarding the finding follow the table.

Noncompliant	Areas Reviewed
	Staff completed competency-based education/training prior to assisting with or providing moderate sedation.
X	Pre-sedation documentation was complete.
	Informed consent was completed appropriately and performed prior to administration of sedation.
	Timeouts were appropriately conducted.
	Monitoring during and after the procedure was appropriate.
	Moderate sedation patients were appropriately discharged.
	The use of reversal agents in moderate sedation was monitored.
	If there were unexpected events/complications from moderate sedation procedures, the numbers were reported to an organization-wide venue.
	If there were complications from moderate sedation, the data was analyzed and benchmarked, and actions taken to address identified problems were implemented and evaluated.
	The facility complied with any additional elements required by local policy.

Pre-Sedation Assessment Documentation. VHA requires that providers document a complete history and physical examination and/or pre-sedation assessment within 30 days prior to a procedure where moderate sedation will be used.[4] Eight patients' EHRs did not include all required elements of the history and physical examination, such as a history of any previous adverse experience with sedation, a review of substance abuse, and risk assessments for the procedure.

Recommendation

7. We recommended that processes be strengthened to ensure that pre-sedation assessment documentation includes all required elements.

[4] VHA Directive 2006-023, *Moderate Sedation by Non-Anesthesia Providers*, May 1, 2006.

QM

The purpose of this review was to determine whether facility senior managers actively supported and appropriately responded to QM efforts and whether the facility complied with selected requirements within its QM program.

We interviewed senior managers and key QM employees, and we evaluated meeting minutes, EHRs, and other relevant documents. The areas marked as noncompliant in the table below needed improvement. Details regarding the findings follow the table.

Noncompliant	Areas Reviewed
	There was a senior-level committee/group responsible for QM/performance improvement, and it included all required members.
	There was evidence that inpatient evaluation data were discussed by senior managers.
X	The protected PR process complied with selected requirements.
	Licensed independent practitioners' clinical privileges from other institutions were properly verified.
	Focused Professional Practice Evaluations for newly hired licensed independent practitioners complied with selected requirements.
	Staff who performed utilization management reviews met requirements and participated in daily interdisciplinary discussions.
	If cases were referred to a physician utilization management advisor for review, recommendations made were documented and followed.
	There was an integrated ethics policy, and an appropriate annual evaluation and staff survey were completed.
	If ethics consultations were initiated, they were completed and appropriately documented.
	There was a cardiopulmonary resuscitation review policy and process that complied with selected requirements.
	Data regarding resuscitation episodes were collected and analyzed, and actions taken to address identified problems were evaluated for effectiveness.
X	If MODs were responsible for responding to resuscitation codes during non-administrative hours, they had current Advanced Cardiac Life Support certification.
	There was an EHR quality review committee, and the review process complied with selected requirements.
	If the evaluation/management coding compliance report contained failures/negative trends, actions taken to address identified problems were evaluated for effectiveness.
	Copy and paste function monitoring complied with selected requirements.
	There was evidence at the senior leadership level that QM, patient safety, and systems redesign were integrated.
	Overall, if significant issues were identified, actions were taken and evaluated for effectiveness.
	Overall, there was evidence that senior managers were involved in performance improvement over the past 12 months.

Noncompliant	Areas Reviewed (continued)
	Overall, the facility had a comprehensive, effective QM/performance improvement program over the past 12 months.
	The facility complied with any additional elements required by local policy.

PR. VHA requires that PR Committee quarterly reports to the Medical Executive Board include specific data analysis elements.[5] We reviewed quarterly reports from July 2011 through June 2012. We found that the reports did not contain all required elements, such as the number of deaths screened or the delinquency rate for the timeliness of reviews. This is a repeat finding from the previous CAP review.

Current Certification. VHA requires MODs designated to respond to calls for resuscitation to maintain current Advanced Cardiac Life Support certification.[6] We found that three of the five providers assigned as an MOD during the week prior to our visit did not have current certification.

Recommendations

8. We recommended that processes be strengthened to ensure that PR Committee quarterly reports to the Medical Executive Board include all required elements.

9. We recommended that processes be strengthened to ensure that MODs designated to respond to calls for resuscitation maintain Advanced Cardiac Life Support certification.

[5] VHA Directive 2010-025, *Peer Review for Quality Management*, June 3, 2010.
[6] VHA Handbook 1101.04, *Medical Officer of the Day*, August 30, 2010.

POCT

The purpose of this review was to evaluate whether the facility's inpatient blood glucose POCT program complied with applicable laboratory regulatory standards and quality testing practices as required by VHA, the College of American Pathologists, and The JC.

We reviewed the EHRs of 50 patients who had glucose testing, 18 employee training and competency records, and relevant documents. We also performed physical inspections of 10 patient care areas where glucose POCT was performed, and we interviewed key employees involved in POCT management. The areas marked as noncompliant in the table below needed improvement. Details regarding the findings follow the table.

Noncompliant	Areas Reviewed
	The facility had a current policy delineating testing requirements and oversight responsibility by the Chief of Pathology and Laboratory Medicine Service.
	Procedure manuals were readily available to staff.
	Employees received training prior to being authorized to perform glucose testing.
	Employees who performed glucose testing had ongoing competency assessment at the required intervals.
	Test results were documented in the EHR.
	Facility policy included follow-up actions required in response to critical test results.
X	Critical test results were appropriately managed.
	Testing reagents and supplies were current and stored according to manufacturers' recommendations.
	Quality control was performed according to the manufacturer's recommendations.
	Routine glucometer cleaning and maintenance was performed according to the manufacturer's recommendations.
X	The facility complied with any additional elements required by local policy.

Test Results Management. VHA requires that critical results requiring follow-up be communicated to the responsible clinician to ensure that appropriate and prompt actions are taken if indicated.[7] Local policy requires that a Critical Values Note template be used to document clinician notification. Seven of the 20 patients who had critical test results did not have ordering clinician notification of the test results documented in their EHRs. Nine additional patients did not have clinician notification documented using the facility's required template.

[7] VHA Directive 2009-019, *Ordering and Reporting Test Results*, March 24, 2009.

Recommendation

10. We recommended that processes be strengthened to ensure that clinicians are consistently notified of critical test results requiring follow-up and that the required template is used for notification.

Nurse Staffing

The purpose of this review was to determine the extent to which the facility implemented the staffing methodology for nursing personnel and to evaluate nurse staffing on one selected acute care unit.

We reviewed relevant documents and 13 training files and interviewed key employees. We also reviewed the actual nursing HPPD for one acute care unit (2N) at the Nashville campus and one acute care unit (1A) at the Murfreesboro campus for 30 randomly selected days (holidays, weekdays, and weekend days) between October 2011 and March 2012. The area marked as noncompliant in the table below needed improvement. Details regarding the finding follow the table.

Noncompliant	Areas Reviewed
	The unit-based expert panels followed the required processes.
	The facility expert panel followed the required processes.
	Members of the expert panels completed the required training.
	The facility completed the required steps to develop a nurse staffing methodology by the deadline.
X	The selected unit's actual nursing HPPD met or exceeded the target nursing HPPD.
	The facility complied with any additional elements required by local policy.

Variance Between Actual Nurse Staffing and Target. VHA requires that the facility's target nursing HPPD be used to plan for staffing and to evaluate actual staffing.[8] Unit 2N's and unit 1A's average actual nursing HPPD were consistently below target for the three groups of days reviewed.

Recommendation

11. We recommended that unit 2N's and unit 1A's nurse managers reassess the target nursing HPPD to more accurately plan for staffing and evaluate the actual staffing provided.

[8] VHA Directive 2010-034, *Staffing Methodology for VHA Nursing Personnel*, July 19, 2010.

Review Activities Without Recommendations

COC

The purpose of this review was to determine whether patients with a primary discharge diagnosis of HF received adequate discharge planning and care "hand-off" and timely primary care or cardiology follow-up after discharge that included evaluation and documentation of HF management key components.

We reviewed 30 HF patients' EHRs and relevant documents and interviewed key employees. The table below details the areas reviewed. The facility generally met requirements. We made no recommendations.

Noncompliant	Areas Reviewed
	Medications in discharge instructions matched those ordered at discharge.
	Discharge instructions addressed medications, diet, and the initial follow-up appointment.
	Initial post-discharge follow-up appointments were scheduled within the providers' recommended timeframes.
	The facility complied with any additional elements required by local policy.

CRC Screening

The purpose of this review was to follow up on a report, *Healthcare Inspection – Colorectal Cancer Detection and Management in Veterans Health Administration Facilities* (Report No. 05-00784-76, February 2, 2006) and to assess the effectiveness of the facility's CRC screening.

We reviewed the EHRs of 20 patients who had CRC screening tests and interviewed key employees involved in CRC management. The table below details the areas reviewed. The facility generally met requirements. We made no recommendations.

Noncompliant	Areas Reviewed
	Patients were notified of positive screening test results within the required timeframe.
	Clinicians responsible for initiating follow-up either developed plans or documented no follow-up was indicated within the required timeframe.
	Patients received a diagnostic test within the required timeframe.
	Patients were notified of the diagnostic test results within the required timeframe.
	Patients who had biopsies were notified within the required timeframe.
	Patients were seen in surgery clinic within the required timeframe.
	The facility complied with any additional elements required by local policy.

Medication Management

The purpose of this review was to determine whether the facility complied with selected requirements for opioid dependence treatment, specifically, opioid agonist[9] therapy with methadone and buprenorphine and handling of methadone.

We reviewed 10 EHRs of patients receiving methadone or buprenorphine for evidence of compliance with program requirements. We also reviewed relevant documents, interviewed key employees, and inspected the methadone storage area (if any). The table below details the areas reviewed. The facility generally met requirements. We made no recommendations.

Noncompliant	Areas Reviewed
	Opioid dependence treatment was available to all patients for whom it was indicated and for whom there were no medical contraindications.
	If applicable, clinicians prescribed the appropriate formulation of buprenorphine.
	Clinicians appropriately monitored patients started on methadone or buprenorphine.
	Program compliance was monitored through periodic urine drug screenings.
	Patients participated in expected psychosocial support activities.
	Physicians who prescribed buprenorphine adhered to Drug Enforcement Agency requirements.
	Methadone was properly ordered, stored, and packaged for home use.
	The facility complied with any additional elements required by local policy.

[9] A drug that has affinity for the cellular receptors of another drug and that produces a physiological effect.

MH Treatment Continuity

The purpose of this review was to evaluate the facility's compliance with VHA requirements related to MH patients' transition from the inpatient to outpatient setting, including follow-up after discharge.

We interviewed key employees and reviewed relevant documents and the EHRs of 28 patients discharged from acute MH (including 8 patients deemed at high risk for suicide). The table below details the areas reviewed. The facility generally met requirements. We made no recommendations.

Noncompliant	Areas Reviewed
	After discharge from a MH hospitalization, patients received outpatient MH follow-up in accordance with VHA policy.
	Follow-up MH appointments were made prior to hospital discharge.
	Outpatient MH services were offered at least one evening per week.
	Attempts to contact patients who failed to appear for scheduled MH appointments were initiated and documented.
	The facility complied with any additional elements required by local policy.

Polytrauma

The purpose of this review was to determine whether the facility complied with selected requirements related to screening, evaluation, and COC for patients affected by polytrauma.

We reviewed relevant documents, 10 EHRs of patients with positive traumatic brain injury results, 10 EHRs of patients followed in the polytrauma clinic, and 10 staff training records, and we interviewed key employees. The table below details the areas reviewed. The facility generally met requirements. We made no recommendations.

Noncompliant	Areas Reviewed
	Providers communicated the results of the traumatic brain injury screening to patients and referred patients for comprehensive evaluations within the required timeframe.
	Providers performed timely, comprehensive evaluations of patients with positive screenings in accordance with VHA policy.
	Case Managers were appropriately assigned to outpatients and provided frequent, timely communication.
	Outpatients who needed interdisciplinary care had treatment plans developed that included all required elements.
	Adequate services and staffing were available for the polytrauma care program.
	Employees involved in polytrauma care were properly trained.
	Case Managers provided frequent, timely communication with hospitalized polytrauma patients.
	The interdisciplinary team coordinated inpatient care planning and discharge planning.
	Patients and their family members received follow-up care instructions at the time of discharge from the inpatient unit.
	Polytrauma-Traumatic Brain Injury System of Care facilities provided an appropriate care environment.
	The facility complied with any additional elements required by local policy.

Comments

The VISN and Facility Directors agreed with the CAP review findings and recommendations and provided acceptable improvement plans. See Appendixes C and D, pages 21–27, for the full text of the Directors' comments. We consider Recommendation 5 closed. We will follow up on the planned actions for the open recommendations until they are completed.

Facility Profile[10]		
Type of Organization	Health care system	
Complexity Level	1a	
VISN	9	
Community Based Outpatient Clinics	Nashville, TN Chattanooga, TN Clarksville, TN Cookeville, TN Bowling Green, TN Hopkinsville, KY McMinnville, TN Rockwood, TN Dover, TN Tullahoma, TN Murfreesboro, TN	
Veteran Population in Catchment Area	299,038	
Type and Number of Total Operating Beds: • **Hospital, including Psychosocial Residential Rehabilitation Treatment Program**	129 – Medicine; 51 – Surgery; 76 – Psychiatry; 4 – Neurology	
• **Community Living Center/Nursing Home Care Unit**	238	
Medical School Affiliation(s)	Vanderbilt University School of Medicine Meharry Medical College	
• **Number of Residents**	117	
	Current FY (through April 2012)	**Prior FY (2011)**
Resources (in millions):		
• **Total Medical Care Budget**	$575	$567
• **Medical Care Expenditures**	$575	$567
Total Medical Care Full-Time Employee Equivalents	3,092	3,089
Workload:		
• **Number of Station Level Unique Patients**	74,586	83,536
• **Inpatient Days of Care:**		
o **Acute Care**	40,399	70,774
o **Community Living Center/Nursing Home Care Unit**	38,215	70,896
Hospital Discharges	6,420	11,154
Total Average Daily Census (including all bed types)	369	388
Cumulative Occupancy Rate (in percent)	75	75
Outpatient Visits	491,812	804,666

[10] All data provided by facility management.

VHA Satisfaction Surveys

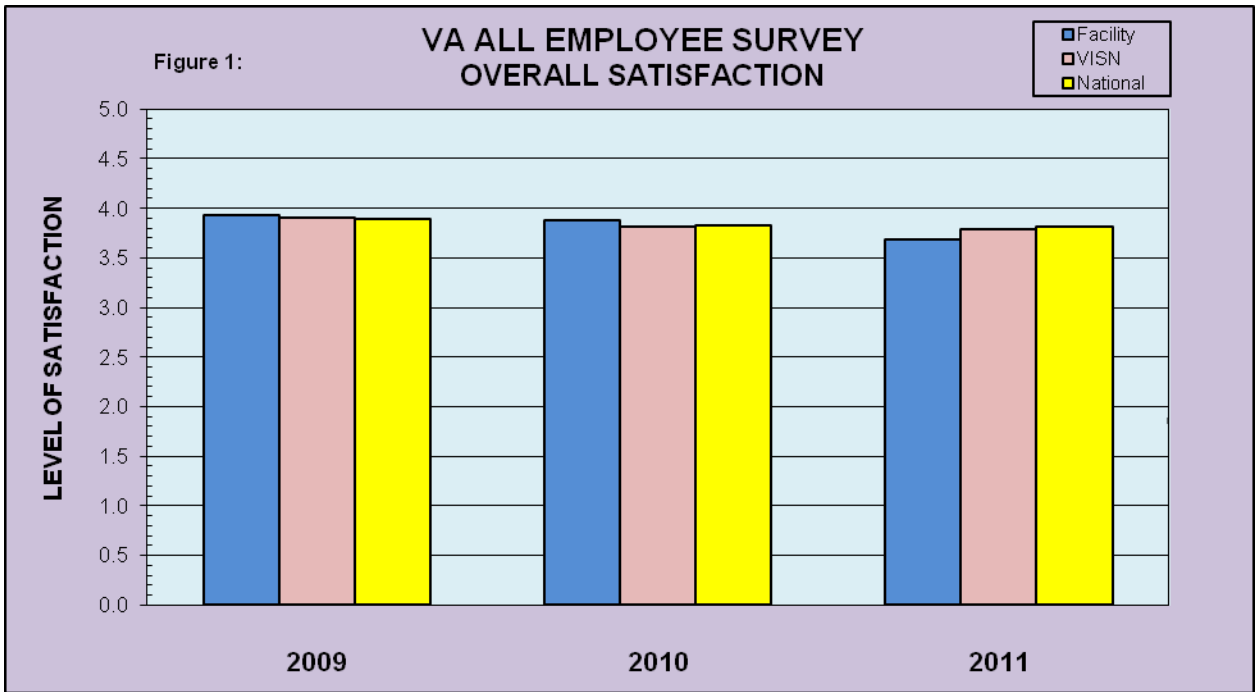
VHA has identified patient and employee satisfaction scores as significant indicators of facility performance. Patients are surveyed monthly. Table 1 below shows facility, VISN, and VHA overall inpatient and outpatient satisfaction scores for quarters 3 and 4 of FY 2011 and quarters 1 and 2 of FY 2012.

Table 1

	Inpatient Scores		Outpatient Scores			
	FY 2011	FY 2012	FY 2011		FY 2012	
	Inpatient Score Quarters 3–4	Inpatient Score Quarters 1–2	Outpatient Score Quarter 3	Outpatient Score Quarter 4	Outpatient Score Quarter 1	Outpatient Score Quarter 2
Facility	63.0	59.7	48.0	48.4	50.6	51.6
VISN	64.8	63.6	55.3	54.3	54.7	54.1
VHA	64.1	63.9	54.2	54.5	55.0	54.7

Employees are surveyed annually. Figure 1 below shows the facility's overall employee scores for 2009, 2010, and 2011. Since no target scores have been designated for employee satisfaction, VISN and national scores are included for comparison.

Figure 1:



Hospital Outcome of Care Measures

Hospital Outcome of Care Measures show what happened after patients with certain conditions received hospital care.[11] Mortality (or death) rates focus on whether patients died within 30 days of being hospitalized. Readmission rates focus on whether patients were hospitalized again within 30 days of their discharge. These rates are based on people who are 65 and older and are "risk-adjusted" to take into account how sick patients were when they were initially admitted. Table 2 below shows facility and U.S. national Hospital Outcome of Care Measure rates for patients discharged between July 1, 2008, and June 30, 2011.[12]

Table 2

	Mortality			Readmission		
	Heart Attack	Congestive HF	Pneumonia	Heart Attack	Congestive HF	Pneumonia
Facility	14.1	10.5	13.2	20.6	26.1	21.1
U.S. National	15.5	11.6	12.0	19.7	24.7	18.5

[11] A heart attack occurs when blood flow to a section of the heart muscle becomes blocked, and the blood supply is slowed or stopped. If the blood flow is not restored timely, the heart muscle becomes damaged. Congestive HF is a weakening of the heart's pumping power. Pneumonia is a serious lung infection that fills the lungs with mucus and causes difficulty breathing, fever, cough, and fatigue.

[12] Rates were calculated from Medicare data and do not include data on people in Medicare Advantage Plans (such as health maintenance or preferred provider organizations) or people who do not have Medicare.

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: September 10, 2012

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

Subject: **CAP Review of the Tennessee Valley Healthcare System, Nashville, TN**

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

Director, Management Review Service (VHA 10AR MRS)

1. I concur with the report and have no comments.

2. Should you need additional information, please contact Tammy Williams, VISN 9 Continuous Readiness Coordinator at (615) 695-2200.

(*original signed by:)*
John Dandridge, Jr.
Director, VA Mid South Healthcare Network (10N9)

Facility Director Comments

Department of Veterans Affairs **Memorandum**

Date: September 10, 2012

From: Director, Tennessee Valley Healthcare System (626/00)

Subject: **CAP Review of the Tennessee Valley Healthcare System, Nashville, TN**

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

I concur with the Office of Inspector General's inspection report and have no comments.

(Janice Cobb, RN, MA, CPHQ,
electronically signed on behalf of:)
Juan A. Morales, RN, MSN
Director, Tennessee Valley Healthcare System (626/00)

Comments to OIG's Report

The following Director's comments are submitted in response to the recommendations in the OIG report:

OIG Recommendations

Recommendation 1. We recommended that processes be strengthened to ensure that EOC Board minutes reflect required elements.

Concur

Target date for completion: 15 January 2013

1. Self identification and discussion leading to progressive program development in the EOC committee is dependent upon identification and distribution of metric based trends. A consolidated dashboard is being developed and coordinated to track and brief pertinent program statistics.

2. This matrix will be briefed by the respective program POC for trending analysis and discussion during committee and subsequent inclusion in the minutes.

3. Minutes will be reviewed monthly for compliance with Joint Commission standards and local policy by the Director's Special Assistant and reported to Quality Executive Board for oversight and action.

Recommendation 2. We recommended that processes be strengthened to ensure that oxygen tanks are properly secured and stored in a manner that distinguishes between empty and full tanks.

Concur

Target date for completion: Completed 31 August 2012

1. Signage on door of hospice storage room and above oxygen storage container was appropriate/correct. Logistics was notified of error in delivery of storage container with "Full" on side of storage rack to empty cylinder area. Signage on front of oxygen tank storage container was immediately corrected on York hospice unit.

2. Small oxygen cylinder storage cart was placed in locked storage room on mental health unit to accommodate small room size and compliance with oxygen storage requirements.

3. TRACERs, including review of oxygen tank storage, are reviewed with Nurse Managers for immediate correction when oxygen tank storage issues are identified.

4. Data trending/analysis will be reported to Nursing CRR Workgroup for action should non-compliance be noted.

Recommendation 3. We recommended that processes be strengthened to ensure that MSDS inventory lists and hazardous material information binders are current and that staff are trained on how to access the electronic MSDS program.

Concur

Target date for completion: 1 October 12

1. Employees have been reminded of electronic MSDS access on all computers.

2. Education has been provided to Managers/Service Chiefs and Supervisors regarding updating of MSDS Binders.

3. The Environment of Care Rounds group will be responsible for following up with every unit to ensure compliance and monitoring for MSDS binders.

4. MSDS access and binders will be included EOC TRACERs.

Recommendation 4. We recommended that processes be strengthened to ensure that the emergency eyewash station in the Nashville campus ED is tested weekly and that this testing is documented.

Concur

Target date for completion: Completed 23 July 2012

1. Eyewash checklist was distributed to all areas with eyewashes. Placement of checklists was validated in all areas by Nurse Managers and first line supervisors.

2. Staff was instructed on completion of documentation requirements and weekly procedure for flow test. Knowledge was validated by return demonstration in all areas.

3. Eyewash documentation and procedure is included in TRACERs.

Recommendation 5. We recommended that the open wall penetration in the surgical unit be properly sealed.

Concur

Target date for completion: Completed July 20, 2012

1. Penetration was sealed with fire caulk on July 20, 2012.

Recommendation 6. We recommended that processes be strengthened to ensure that safety inspections are conducted and documented on all ceiling lifts in the Murfreesboro campus SCI outpatient clinic.

Concur

Target date for completion: 1 October 2012

1. Safety inspections will be completed and documented on all ceiling lifts in the SCI outpatient clinic.

2. Biomed and Safe Patient Handling are working to replace these lifts with newer lifts with the goal of standaridazation to one vendor.

3. Once replaced, the new lifts will be tested and maintained annually by the current service contract.

Recommendation 7. We recommended that processes be strengthened to ensure that pre-sedation assessment documentation includes all required elements.

Concur

Target date for completion: 1 November 2012

1. Pre-procedure template has been updated to include all requirements.

2. Pre-procedure template has been piloted and revised to improve physician access and compliance.

3. Request has been forwarded to IRM to change current name of template to "Pre-procedure Template."

4. Moderate Sedation Workgroup has reviewed and approved template. Template will be forwarded to CPR Committee for concurrence.

5. Physicians will be educated by COS Office concerning requirement to utilize template for all pre-procedure documentation for moderate sedation.

Recommendation 8. We recommended that processes be strengthened to ensure that PR Committee quarterly reports to the Medical Executive Board include all required elements.

Concur

Target date for completion: 15 March 2013 for monitoring

1. Risk Manager will report Peer Review Committee information to MEB quarterly.

2. The Peer Review reporting template for MEB has been revised to include all required elements including the number of deaths screen and delinquency rate for reviews.

3. The MEB Meeting has been rescheduled to meet at the beginning of each month (instead of the end of the month) in an effort to prevent "out of cycle" reporting with a canceled meeting at the end of the month.

Recommendation 9. We recommended that processes be strengthened to ensure that MODs designated to respond to calls for resuscitation maintain Advanced Cardiac Life Support certification.

Concur

Target date for completion: 15 March 2013 for monitoring

1. The Associate Chief of Staff will communicate to the residents the requirement to maintain an active Advanced Cardiac Life Support (ACLS) certification via the respective Graduate Medical Education monthly meetings.

2. Both affiliates—Meharry Medical College and Vanderbilt University Medical Center—have processes currently in place to monitor their residents to assure their training has been completed and have provided letters for TVHS stating such processes are in place.

3. The Associate Chief of Staff for Education will request quarterly updates from the affiliates regarding the status of current ACLS certification of residents who will be rotating at TVHS and provide us with copies of current ACLS certification cards for our records.

4. TVHS Education Service will make its ACLS Courses available to residents who need either initial certification or recertification.

5. All incoming residents will be certified in ACLS each July as a part of their orientation process.

Recommendation 10. We recommended that processes be strengthened to ensure that clinicians are consistently notified of critical test results requiring follow-up and that the required template is used for notification.

Concur

Target date for completion: 15 December 2012

1. "Did You Know" flyer has been distributed to remind nurses of requirement to notify clinicians on critical care template of critical test results.

2. Compliance with local policy will assessed through monthly monitoring of the Electronic Healthcare Record by Clinical Nurse Leaders. This information will be reviewed by the Nursing CRR Workgroup and actions developed should non-compliance be determined.

3. Patient Safety "Notepad" will be used to document critical values and promote timely transfer of the information to the critical value templates after physician notification.

4. Local policy will be reviewed and suggestions submitted to policy owners to improve the current notification documentation process.

Recommendation 11. We recommended that unit 2N's and unit 1A's nurse managers reassess the target nursing HPPD to more accurately plan for staffing and evaluate the actual staffing provided.

Concur

Target date for completion: 1 November 2012

1. TVHS completed Staffing Methodology training and presentations as required by the VHA Directive by the original due date.

2. FTEE are continually monitored and weekly meetings with Nursing and Human Resources track the hiring processes and EOD dates. Travel, Contract and Agency supplement TVHS staff.

3. A review of staffing for 2N and 1A has been completed and submitted to the Associate Director, Nursing Service for approval. Between 2N and 1A, a total of four LPN positions have been converted to RN positions so far with the goal of 68 percent RN on all Medical/Surgical floors. Additional requests for position conversions and additions based on the NHPPD are pending submission and approval.

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