
**Department of Veterans Affairs**
**Office of Inspector General**

**Office of Healthcare Inspections**

**Report No. 12-04605-107**

# Combined Assessment Program Review of the G.V. (Sonny) Montgomery VA Medical Center Jackson, Mississippi

**February 7, 2013**

**Washington, DC 20420**

**To Report Suspected Wrongdoing in VA Programs and Operations**
**Telephone: 1-800-488-8244**
**E-Mail:** vaoighotline@va.gov
**(Hotline Information: http://www.va.gov/oig/hotline/default.asp)**

# Glossary

| | |
|---|---|
| CAP | Combined Assessment Program |
| CLC | community living center |
| CS | controlled substances |
| EHR | electronic health record |
| EOC | environment of care |
| facility | G.V. (Sonny) Montgomery VA Medical Center |
| FPPE | Focused Professional Practice Evaluation |
| FY | fiscal year |
| HPC | hospice and palliative care |
| LTHOT | long-term home oxygen therapy |
| NA | not applicable |
| NC | noncompliant |
| OIG | Office of Inspector General |
| PCCT | Palliative Care Consult Team |
| QM | quality management |
| VHA | Veterans Health Administration |
| VISN | Veterans Integrated Service Network |

# Table of Contents

# Executive Summary

**Review Purpose:** The purpose of the review was to evaluate selected health care facility operations, focusing on patient care quality and the environment of care, and to provide crime awareness briefings. We conducted the review the week of December 10, 2012.

**Review Results:** The review covered seven activities. We made no recommendations in the following two activities:

- Medication Management – Controlled Substances Inspections
- Coordination of Care – Hospice and Palliative Care

The facility's reported accomplishment was its Long-Term Home Oxygen Therapy Program team. When the team became aware of grants for fire alarms and fire hazards training, they completed the training and implemented a smoke alarm program for veterans in the home oxygen program.

**Recommendations:** We made recommendations in the following five activities:

*Quality Management:* Ensure results of Focused Professional Practice Evaluations for newly hired licensed independent practitioners are reported timely to the Medical Executive Committee. Perform continued stay reviews on at least 75 percent of patients in acute beds.

*Environment of Care:* Ensure actions implemented to address high-risk areas are documented in Infection Control Committee minutes. Require patient care areas to be clean, and monitor compliance. Date multi-dose medication vials when opened.

*Long-Term Home Oxygen Therapy:* Ensure that high-risk home oxygen patients receive education on the hazards of smoking while oxygen is in use at the required intervals and that the education is documented.

*Nurse Staffing:* Ensure that the identified units' expert panels reassess the inpatient staffing needed following the required processes and that the annual staffing plan reassessment process ensures that the facility expert panel includes all required members.

*Preventable Pulmonary Embolism:* Initiate a protected peer review for the two identified patients, and complete any recommended review actions.

## Comments

The Veterans Integrated Service Network and Facility Directors agreed with the Combined Assessment Program review findings and recommendations and provided acceptable improvement plans. (See Appendixes C and D, pages 14–19, for the full text of the Directors' comments.) 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 quality and the EOC.
- 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 compliance with requirements related to patient care quality and the EOC. In performing the review, we inspected selected areas, interviewed managers and employees, and reviewed clinical and administrative records. The review covered the following seven activities:

- QM
- EOC
- Medication Management – CS Inspections
- Coordination of Care – HPC
- LTHOT
- Nurse Staffing
- Preventable Pulmonary Embolism

We have listed the general information reviewed for each of these activities. Some of the items listed may 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, FY 2012, and FY 2013 through December 10, 2012, and was done in accordance with OIG standard operating procedures for CAP reviews. We also asked the facility to provide the status on the recommendations we made in our previous CAP report (*Combined Assessment Program Review of the G.V. (Sonny) Montgomery VA Medical Center, Jackson, Mississippi,* Report No. 11-01608-273, September 8, 2011).

During this review, we presented crime awareness briefings for 218 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 295 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

## LTHOT Program

The facility's LTHOT Program team manages the entire home oxygen program without the use of contracts. This includes ordering equipment and supplies, teaching patients and their families how to safely use oxygen, and providing ongoing follow-up by telephone and through home and clinic visits.

The LTHOT Program team discovered that grants were available through the state of Mississippi for the installation of fire alarms and fire hazards training. The team developed a partnership with the Mississippi State Fire Marshal's Office to install smoke alarms in veterans' homes and increase fire hazard awareness. The Mississippi State Fire Marshal's Office provided the fire alarms at no cost but had limited resources to install the alarms and provide in-home training. The LTHOT Program team completed the training provided by the fire marshals and implemented a smoke alarm program. As a result, 75 alarms have been installed at no cost to the veterans. By expanding the role of the team, the facility was able to provide additional equipment and training beyond program requirements to help veterans prevent home oxygen related fires that could result in serious injury and possibly death.

# Results and Recommendations

## 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.[1]

We interviewed senior managers and key QM employees, and we evaluated meeting minutes, EHRs, and other relevant documents. The table below shows the areas reviewed for this topic. The areas marked as NC needed improvement. Items that did not apply to this facility are marked "NA."

| NC | Areas Reviewed | Findings |
|---|---|---|
| | There was a senior-level committee/group responsible for QM/performance improvement, and it included the required members. | |
| | There was evidence that Inpatient Evaluation Center data was discussed by senior managers. | |
| | Corrective actions from the protected peer review process were reported to the Peer Review Committee. | |
| X | FPPEs for newly hired licensed independent practitioners complied with selected requirements. | Eight profiles reviewed:<br>• Of the seven FPPEs completed, results of five were not reported timely to the Medical Executive Committee. |
| | Local policy for the use of observation beds complied with selected requirements. | |
| | Data regarding appropriateness of observation bed use was gathered, and conversions to acute admissions were less than 30 percent. | |
| X | Staff performed continuing stay reviews on at least 75 percent of patients in acute beds. | Twelve months of continuing stay data reviewed:<br>• For all 12 months, less than 75 percent of acute inpatients were reviewed. |
| | Appropriate processes were in place to prevent incidents of surgical items being retained in a patient following surgery. | |
| | The cardiopulmonary resuscitation review policy and processes complied with requirements for reviews of episodes of care where resuscitation was attempted. | |
| | There was an EHR quality review committee, and the review process complied with selected requirements. | |

| NC | Areas Reviewed (continued) | Findings |
|---|---|---|
| | The EHR copy and paste function was monitored. | |
| | Appropriate quality control processes were in place for non-VA care documents, and the documents were scanned into EHRs. | |
| | Use and review of blood/transfusions complied with selected requirements. | |
| | CLC minimum data set forms were transmitted to the data center monthly. | |
| | Overall, if significant issues were identified, actions were taken and evaluated for effectiveness. | |
| | There was evidence at the senior leadership level that QM, patient safety, and systems redesign were integrated. | |
| | Overall, there was evidence that senior managers were involved in performance improvement over the past 12 months. | |
| | 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 VHA or local policy. | |

## Recommendations

**1.** We recommended that processes be strengthened to ensure that results of FPPEs for newly hired licensed independent practitioners are reported timely to the Medical Executive Committee.

**2.** We recommended that processes be strengthened to ensure that continued stay reviews are performed on at least 75 percent of patients in acute beds.

## EOC

The purpose of this review was to determine whether the facility maintained a clean and safe health care environment in accordance with applicable requirements.[2]

We inspected the medicine, surgery, intensive care, and mental health units; the CLC; the emergency department; the women's health clinic located in a general primary care clinic; and two physical medicine and rehabilitation therapy clinics. Additionally, we reviewed relevant documents and interviewed key employees and managers. The table below shows the areas reviewed for this topic. The areas marked as NC needed improvement. Items that did not apply to this facility are marked "NA."

| NC | Areas Reviewed for General EOC | Findings |
|---|---|---|
| | EOC Committee minutes reflected sufficient detail regarding identified deficiencies, corrective actions taken, and tracking of corrective actions to closure. | |
| X | An infection prevention risk assessment was conducted, and actions were implemented to address high-risk areas. | Infection prevention risk assessment and 8 months of Infection Control Committee meeting minutes reviewed:<br>• Minutes did not reflect that actions were implemented to address high-risk areas. |
| | Infection Prevention/Control Committee minutes documented discussion of identified problem areas and follow-up on implemented actions and included analysis of surveillance activities and data. | |
| | The facility had a policy that detailed cleaning of equipment between patients. | |
| X | Patient care areas were clean. | • Two of the nine units/areas inspected were not clean. |
| | Fire safety requirements were met. | |
| | Environmental safety requirements were met. | |
| | Infection prevention requirements were met. | |
| X | Medication safety and security requirements were met. | • On four units, opened multi-dose medication vials were not dated so that staff would know when they would expire. |
| | Sensitive patient information was protected, and patient privacy requirements were met. | |
| | The facility complied with any additional elements required by VHA, local policy, or other regulatory standards. | |
| | **Areas Reviewed for the Women's Health Clinic** | |
| | The Women Veterans Program Manager completed required annual EOC evaluations and tracked identified deficiencies to closure. | |
| | Fire safety requirements were met. | |
| | Environmental safety requirements were met. | |

| NC | Areas Reviewed for the Women's Health Clinic (continued) | Findings |
|---|---|---|
| | Infection prevention requirements were met. | |
| | Medication safety and security requirements were met. | |
| | Patient privacy requirements were met. | |
| | The facility complied with any additional elements required by VHA, local policy, or other regulatory standards. | |
| | **Areas Reviewed for Physical Medicine and Rehabilitation Therapy Clinics** | |
| | Fire safety requirements were met. | |
| | Environmental safety requirements were met. | |
| | Infection prevention requirements were met. | |
| NA | Medication safety and security requirements were met. | |
| | Patient privacy requirements were met. | |
| | The facility complied with any additional elements required by VHA, local policy, or other regulatory standards. | |

## Recommendations

**3.** We recommended that processes be strengthened to ensure that actions implemented to address high-risk areas are documented in Infection Control Committee minutes.

**4.** We recommended that processes be strengthened to ensure that patient care areas are clean and that compliance be monitored.

**5.** We recommended that processes be strengthened to ensure that multi-dose medication vials are dated when opened.

## Medication Management – CS Inspections

The purpose of this review was to determine whether the facility complied with requirements related to CS security and inspections.[3]

We reviewed relevant documents and interviewed key employees. We also reviewed the training files of all CS Coordinators and 10 CS inspectors and inspection documentation from 10 CS areas, the inpatient and outpatient pharmacies, and the emergency drug cache. The table below shows the areas reviewed for this topic. Items that did not apply to this facility are marked "NA." The facility generally met requirements. We made no recommendations.

| NC | Areas Reviewed | Findings |
|---|---|---|
| | Facility policy was consistent with VHA requirements. | |
| | VA police conducted annual physical security surveys of the pharmacy/pharmacies, and any identified deficiencies were corrected. | |
| | Instructions for inspecting automated dispensing machines were documented, included all required elements, and were followed. | |
| | Monthly CS inspection findings summaries and quarterly trend reports were provided to the facility Director. | |
| | CS Coordinator position description(s) or functional statement(s) included duties, and CS Coordinator(s) completed required certification and were free from conflicts of interest. | |
| | CS inspectors were appointed in writing, completed required certification and training, and were free from conflicts of interest. | |
| | Non-pharmacy areas with CS were inspected in accordance with VHA requirements, and inspections included all required elements. | |
| | Pharmacy CS inspections were conducted in accordance with VHA requirements and included all required elements. | |
| | The facility complied with any additional elements required by VHA or local policy. | |

## Coordination of Care – HPC

The purpose of this review was to determine whether the facility complied with selected requirements related to HPC, including PCCT, consults, and inpatient services.[4]

We reviewed relevant documents, 20 EHRs of patients who had PCCT consults (including 10 HPC inpatients), and 25 employee training records (10 HPC staff records and 15 non-HPC staff records), and we interviewed key employees. The table below shows the areas reviewed for this topic. Items that did not apply to this facility are marked "NA." The facility generally met requirements. We made no recommendations.

| NC | Areas Reviewed | Findings |
|---|---|---|
| | A PCCT was in place and had the dedicated staff required. | |
| | The PCCT actively sought patients appropriate for HPC. | |
| | The PCCT offered end-of-life training. | |
| | HPC staff and selected non-HPC staff had end-of-life training. | |
| | The facility had a VA liaison with community hospice programs. | |
| | The PCCT promoted patient choice of location for hospice care. | |
| | The CLC-based hospice program offered bereavement services. | |
| | The HPC consult contained the word "palliative" or "hospice" in the title. | |
| | HPC consults were submitted through the Computerized Patient Record System. | |
| | The PCCT responded to consults within the required timeframe and tracked consults that had not been acted upon. | |
| | Consult responses were attached to HPC consult requests. | |
| | The facility submitted the required electronic data for HPC through the VHA Support Service Center. | |
| | An interdisciplinary team care plan was completed for HPC inpatients within the facility's specified timeframe. | |
| | HPC inpatients were assessed for pain with the frequency required by local policy. | |
| | HPC inpatients' pain was managed according to the interventions included in the care plan. | |
| | HPC inpatients were screened for an advanced directive upon admission and according to local policy. | |
| | The facility complied with any additional elements required by VHA or local policy. | |

## LTHOT

The purpose of this review was to determine whether the facility complied with requirements for LTHOT in its mandated Home Respiratory Care Program.[5]

We reviewed relevant documents and 35 EHRs of patients enrolled in the home oxygen program (including 11 patients deemed to be high risk), and we interviewed key employees. The table below shows the areas reviewed for this topic. The area marked as NC needed improvement. Items that did not apply to this facility are marked "NA."

| NC | Areas Reviewed | Findings |
|---|---|---|
| | There was a local policy to reduce the fire hazards of smoking associated with oxygen treatment. | |
| | The Chief of Staff reviewed Home Respiratory Care Program activities at least quarterly. | |
| | The facility had established a home respiratory care team. | |
| | Contracts for oxygen delivery contained all required elements and were monitored quarterly. | |
| | Home oxygen program patients had active orders/prescriptions for home oxygen and were re-evaluated for home oxygen therapy annually after the first year. | |
| X | Patients identified as high risk received hazards education at least every 6 months after initial delivery. | • Five high-risk patients' EHRs did not contain documentation of education on the hazards of smoking while oxygen is in use at the required intervals. |
| | NC high-risk patients were identified and referred to a multidisciplinary clinical committee for review. | |
| | The facility complied with any additional elements required by VHA or local policy. | |

### Recommendation

**6.** We recommended that processes be strengthened to ensure that high-risk home oxygen patients receive education on the hazards of smoking while oxygen is in use at the required intervals and that the education be documented.

## 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 two selected units (acute care and long-term care).[6]

We reviewed relevant documents and 14 training files, and we interviewed key employees. Additionally, we reviewed the actual nursing hours per patient day for acute care unit 4C North and CLC unit First Floor for 50 randomly selected days (holidays, weekdays, and weekend days) between October 1, 2011, and September 30, 2012. The table below shows the areas reviewed for this topic. The areas marked as NC needed improvement. Items that did not apply to this facility are marked "NA."

| NC | Areas Reviewed | Findings |
|---|---|---|
| X | The unit-based expert panels followed the required processes. | • Unit 4C North and CLC First Floor's panels did not conduct comparative analysis, make recommendations for target nursing hours per patient day, or calculate daily staffing requirements for the individual units. |
| X | The facility expert panel followed the required processes and included all required members. | • The facility panel did not include nurse managers from the various areas of the facility. |
| | Members of the expert panels completed the required training. | |
| | The facility completed the required steps to develop a nurse staffing methodology by September 30, 2011. | |
| | The selected units' actual nursing hours per patient day met or exceeded the target nursing hours per patient day. | |
| | The facility complied with any additional elements required by VHA or local policy. | |

### Recommendations

**7.** We recommended that unit 4C North's expert panel and CLC unit First Floor's expert panel reassess the inpatient staffing needed following the required processes.

**8.** We recommended that the annual staffing plan reassessment process ensure that the facility expert panel includes all required members.

## Preventable Pulmonary Embolism

The purpose of this review was to evaluate the care provided to patients who were treated at the facility and developed potentially preventable pulmonary embolism.[7]

We reviewed relevant documents and 15 EHRs of patients with confirmed diagnoses of pulmonary embolism[a] January 1–June 30, 2012. We also interviewed key employees. The table below shows the areas reviewed for this topic. The areas marked as NC needed improvement. Items that did not apply to this facility are marked "NA."

| NC | Areas Reviewed | Findings |
|---|---|---|
| X | Patients with potentially preventable pulmonary emboli received appropriate anticoagulation medication prior to the event. | • One patient was identified as having a potentially preventable pulmonary embolism because he had risk factors and had not been provided anticoagulation medication. |
| X | No additional quality of care issues were identified with the patients' care. | • One patient was identified as having a potential delay in the diagnosis of his pulmonary embolism. |
| | The facility complied with any additional elements required by VHA or local policy/protocols. | |

### Recommendation

**9.** We recommended that managers initiate a protected peer review for the two identified patients and complete any recommended review actions.

[a] A sudden blockage in a lung artery usually caused by a blood clot that travels to the lung from a vein in the body, most commonly in the legs.

| Facility Profile (Jackson/586) FY 2012[b] | |
|---|---|
| **Type of Organization** | Tertiary |
| **Complexity Level** | 1b-High complexity |
| **Affiliated/Non-Affiliated** | Affiliated |
| **Total Medical Care Budget in Millions** | $322.2 |
| **Number of:** | |
| • **Unique Patients** | 45,722 |
| • **Outpatient Visits** | 433,970 |
| • **Unique Employees[c] (as of the last pay period in FY 2012)** | 1,725 |
| **Type and Number of Operating Beds:** | |
| • **Hospital** | 128 |
| • **CLC** | 86 |
| • **Mental Health** | 27 |
| **Average Daily Census: (through August 2012)** | |
| • **Hospital** | 85 |
| • **CLC** | 73 |
| • **Mental Health** | 24 |
| **Number of Community Based Outpatient Clinics** | 7 |
| **Location(s)/Station Number(s)** | Durant/586GA<br>Meridian/586GB<br>Greenville/586GC<br>Hattiesburg/586GD<br>Natchez/586GE<br>Columbus/586GF<br>McComb/586GG |
| **VISN Number** | 16 |

[b] All data is for FY 2012 except where noted.
[c] Unique employees involved in direct medical care (cost center 8200).

# VHA Patient Satisfaction Survey

VHA has identified patient satisfaction scores as significant indicators of facility performance. Patients are surveyed monthly. Table 1 below shows facility, VISN, and VHA overall inpatient satisfaction scores for quarters 3–4 of FY 2011 and quarters 1–2 of FY 2012 and outpatient satisfaction scores for quarter 4 of FY 2011 and quarters 1–3 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 4 | Outpatient Score Quarter 1 | Outpatient Score Quarter 2 | Outpatient Score Quarter 3 |
| Facility | 71.8 | 65.8 | 57.6 | 56.4 | 62.9 | 46.5 |
| VISN | 65.9 | 64.1 | 50.7 | 52.3 | 50.9 | 50.6 |
| VHA | 64.1 | 63.9 | 54.5 | 55.0 | 54.7 | 54.3 |

# Hospital Outcome of Care Measures

Hospital Outcome of Care Measures show what happened after patients with certain conditions received hospital care.[d] 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.[e]

**Table 2**

| | Mortality | | | Readmission | | |
|---|---|---|---|---|---|---|
| | Heart Attack | Heart Failure | Pneumonia | Heart Attack | Heart Failure | Pneumonia |
| Facility | 16.8 | 12.5 | 14.7 | 23.0 | 25.9 | 22.0 |
| U.S. National | 15.5 | 11.6 | 12.0 | 19.7 | 24.7 | 18.5 |

[d] 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. Heart failure 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.

[e] 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.

**Appendix C**

# VISN Director Comments

**Department of Veterans Affairs** **Memorandum**

**Date:** January 18, 2013

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

**Subject:** **CAP Review of the G.V. (Sonny) Montgomery VA Medical Center, Jackson, MS**

**To:** Director, Dallas Office of Healthcare Inspections (54DA)

Director, Management Review Service (VHA 10AR MRS OIG CAP CBOC)

1. The South Central VA Health Care Network concurs with the response from the G.V. (Sonny) Montgomery VA Medical Center.

2. If you have any questions, please contact Myrtle Tate, Quality Management Officer at (601) 206-7027.

*(original signed by:)*
Rica Lewis-Payton, MHA, FACHE
Director, South Central VA Health Care Network (10N16)

# Facility Director Comments

**Department of Veterans Affairs** **Memorandum**

**Date:** January 18, 2013

**From:** Director, G.V. (Sonny) Montgomery VA Medical Center (586/00)

**Subject:** **CAP Review of the G.V. (Sonny) Montgomery VA Medical Center, Jackson, MS**

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

Please see below our facility response to the recommendations made by the CAP review team during their recent visit during December 2012.

*(original signed by:)*
Joe D. Battle
Director, G.V. (Sonny) Montgomery VA Medical Center (586/00)

# 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 results of FPPEs for newly hired licensed independent practitioners are reported timely to the Medical Executive Committee.

Concur

Target date for completion: 1/30/2013

Facility response:

1.a. Center Policy Memorandum (CPM) F-11-48, Medical Staff Focused Professional Practice Evaluation and Ongoing Professional Practice Evaluation (FPPE/OPPE) was revised to include specifics on the revised facility FPPE process.

b. An FPPE Reporting Form that includes FPPE outcomes was developed. Each service is now required to submit the completed form to the Professional Standards Board (PSB), who will review results, document in the minutes, and submit monthly to the Clinical Executive Board (CEB).

c. The completed FPPE Report Form is now being added to the C&P folder with a copy also being maintained by the applicable Service.

2. To strengthen the above processes, the following CPMs were also updated:

a. K-11P-60, Credentialing and Privileging policy dated 12/31/12 (revision now includes instructions on the revised FPPE/OPPE privileging process).

b. BRD-1109, Professional Standard Board policy dated 12/10/12.

3. Training on the FPPE/OPPE process was provided to facility Leadership/Service Chiefs/designees by the VISN Joint Commission Consultant on 12/28–29/2012.

4. The Quality Management Specialist assigned to the medical staff has developed a tracking sheet that will be utilized to continuously monitor compliance of each service with the revised requirements for FPPE/OPPE. Non-compliance will be immediately reported to the Chief of Staff, and documented in the PSB minutes. PSB minutes will be forwarded to Leadership through the CEB and the Executive Board of the Governing Body (EBGB).

**Recommendation 2.** We recommended that processes be strengthened to ensure that continued stay reviews are performed on at least 75 percent of patients in acute beds.

Concur

Target date for completion: 05/2013

Facility response: Facility will perform a resource allocation review to determine requirements needed for Utilization Management (UM) to achieve the minimal of 75% of continued stay reviews. This review will be completed by 02/29/2013. In the interim, the Center Director has detailed a registered nurse to the UM section to assist with completing the required 75% continued stay reviews. The UM Coordinator will continue to report compliance monthly to Leadership through the Clinical Executive Board, Quality Executive Board, and the Executive Board of the Governing Body.

**Recommendation 3.** We recommended that processes be strengthened to ensure that actions implemented to address high-risk areas are documented in Infection Control Committee minutes.

Concur

Target date for completion: 01/25/2013

Facility response: Documentation/discussion of the actions implemented to address high-risk areas will now be included under the "Monitors" section in the IC minutes. Compliance will be monitored by ongoing review of Infection Control minutes by Assistant Chief, Office of Quality Management.

**Recommendation 4.** We recommended that processes be strengthened to ensure that patient care areas are clean and that compliance be monitored.

Concur

Target date for completion: 05/01/2013

Facility response: The two patient care areas cited were thoroughly cleaned while the inspectors were on station. The facility hired an Assistant Housekeeping Officer to aid in improving compliance and monitoring in patient care areas. Plans have also been initiated to fill the Housekeeping Supervisor position for the applicable wards. A contractor has been on site to furnish estimates for phased replacement of the integral cove moldings in the bathrooms and patient care rooms on wards 2AN and 2AS. The Housekeeping Staff were re-educated by the Associate Chief, Facility Management Service during their January monthly staff meeting on the detailed processes that are to be utilized when cleaning bathrooms and patient care rooms on 2A and other patient wards.

A monitoring system has been implemented by Facility Management Service that requires Housekeeping Supervisors to submit monitoring checklists weekly to the

Assistant Housekeeping Officer for all patient care areas. The Assistant Housekeeping Officer is also performing ongoing environmental rounds in patient care areas to ensure compliance with the required cleaning processes.

**Recommendation 5.** We recommended that processes be strengthened to ensure that multi-dose medication vials are dated when opened.

Concur

Target date for completion: 02/28/2013

Facility response: (Department) – Strengthen our facility process by deploying end-of-shift reports to ensure all expiration dates and documentation is validated for multi-dose medications/vials on the medication checklist when the hand-off report is completed.

(Outpatient) – Strengthen our facility process by deploying daily reports to ensure all expiration dates and documentation is validated for multi-dose medications/vials on the medication checklist at end of the day reporting.

Reports will be submitted to the Nurse Managers of each area weekly for three months or until ongoing compliance of 90% is maintained.

**Recommendation 6.** We recommended that processes be strengthened to ensure that high-risk home oxygen patients receive education on the hazards of smoking while oxygen is in use at the required intervals and that the education be documented.

Concur

Target date for completion: Ongoing

Facility response: Prior to the OIG site visit, the facility identified this issue and implemented corrective actions to ensure that education on the hazards of smoking during oxygen use is provided and documented at the required intervals to high-risk home oxygen patients. A template that addresses the required educational components was developed and implemented for use by the Home Oxygen staff. During the site visit, the surveyor agreed that the template met the requirement. Compliance is being monitored by the Home Oxygen Respiratory Therapist and reported to the Home Care Advisory Board monthly.

**Recommendation 7.** We recommended that unit 4C North's expert panel and CLC unit First Floor's expert panel reassess the inpatient staffing needed following the required processes.

Concur

Target date for completion: On-going re-assessment with completed assessment submitted to the Facility Expert Panel by May 1, 2013 (In-Progress)

Facility response: The staffing methodology process was revised to conduct a comparative analysis for units 4CN and FF-CLC to include the targeted NHPPD along with the calculations for daily staff.

**Recommendation 8.** We recommended that the annual staffing plan reassessment process ensure that the facility expert panel includes all required members.

Concur

Target date for completion: 02/28/2013

Facility response: Membership of the Facility Expert Panel is being revised to include all required staff members. Membership will be reported to OIG upon completion of appointments.

**Recommendation 9.** We recommended that managers initiate a protected peer review for the two identified patients and complete any recommended review actions.

Concur

Target date for completion: 02/2013

Facility response: An Internal Peer review was requested for the two identified Veterans. Peer review was completed on Veteran #1 and sent to the Peer Review Committee with final results of a Level 1. Peer Review on Veteran #2 has been assigned but not completed. Upon completion, results will be evaluated by the Peer Review Committee during the February meeting.

The Critical Care Director presented education regarding pulmonary embolism, and emphasized the importance of DVT Prophylaxis documentation, risk/benefits, and contraindications if no DVT prophylaxis is given. This education was presented during the Medical Service morning report to the in-house medical staff and Attending Physicians.

# OIG Contact and Staff Acknowledgments

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# Endnotes

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