Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 14-02068-264

Combined Assessment Program Review of the Grand Junction VA Medical Center Grand Junction, Colorado

September 2, 2014

Washington, DC 20420

To Report Suspected Wrongdoing in VA Programs and Operations
Telephone: 1-800-488-8244
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Glossary

AIS	acute ischemic stroke
CAP	Combined Assessment Program
CLC	community living center
CRC	colorectal cancer
ED	emergency department
EHR	electronic health record
EOC	environment of care
facility	Grand Junction VA Medical Center
FY	fiscal year
MEC	Medical Executive Committee
MH	mental health
MRI	magnetic resonance imaging
NA	not applicable
NM	not met
OIG	Office of Inspector General
PACU	post-anesthesia care unit
PRC	Peer Review Committee
QM	quality management
SDS	same day surgery
tPA	tissue plasminogen activator
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 July 7, 2014.

Review Results: The review covered seven activities and one follow-up review area from the previous Combined Assessment Program review. We made no recommendations in the following two activities:

- Medication Management
- Coordination of Care

Recommendations: We made recommendations in the following five activities and follow-up area:

Quality Management: Ensure the Medical Executive Committee discusses and documents its approval of the use of another facility's providers for teledermatology services. Consistently perform continuing stay reviews on at least 75 percent of patients in acute beds. Review the quality of entries in the electronic health record. Ensure the Blood Usage Review Committee member from Anesthesia Service consistently attends meetings.

Environment of Care: Install nurse call system alarms in the emergency department. Date multi-dose medication vials when opened, and promptly remove expired medications from patient care areas.

Acute Ischemic Stroke Care: Develop an acute ischemic stroke policy that addresses all required items, and fully implement the policy. Complete and document National Institutes of Health stroke scales for each stroke patient. Post stroke guidelines in the emergency department, on the critical care unit, and on all inpatient units. Screen patients for difficulty swallowing prior to oral intake, and provide printed stroke education to patients upon discharge. Collect and report to the Veterans Health Administration the percent of eligible patients given tissue plasminogen activator, the percent of patients with stroke symptoms who had the stroke scale completed, and the percent of patients screened for difficulty swallowing before oral intake.

Community Living Center Resident Independence and Dignity: Ensure the Restorative Care Coordinator documents patient restorative program goals and progress weekly in accordance with facility policy.

Magnetic Resonance Imaging Safety: Complete initial patient safety screenings, and document them in patients' electronic health records. Complete secondary patient safety screenings immediately prior to magnetic resonance imaging, and place them in patients' electronic health records. Identify any contraindications, and document

resolution prior to magnetic resonance imaging. Ensure Level 2 personnel conducting secondary screenings sign the forms prior to the scan.

Follow-Up on Colorectal Cancer Screening: Implement processes to monitor compliance with colorectal cancer timeliness and patient notification requirements.

Comments

The Acting Veterans Integrated Service Network Director and Facility Director agreed with the Combined Assessment Program review findings and recommendations and provided acceptable improvement plans. (See Appendixes C and D, pages 21–28, 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

The scope of the CAP review is limited. Serious issues that come to our attention that are outside the scope will be considered for further review separate from the CAP process and may be referred accordingly.

For this review, we examined selected clinical and administrative activities to determine whether facility performance met requirements related to patient care quality and the EOC. In performing the review, we inspected selected areas, conversed with managers and employees, and reviewed clinical and administrative records. The review covered the following seven activities and follow-up review area from the previous CAP review:

- QM
- EOC
- Medication Management
- Coordination of Care
- AIS Care
- CLC Resident Independence and Dignity
- MRI Safety
- Follow-Up on CRC Screening

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 2012, FY 2013, and FY 2014 through July 7, 2014, 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 Grand Junction VA Medical Center, Grand Junction, Colorado,* Report No. 11-03657-62, January 12, 2012). We made a recommendation in CRC Screening.

During this review, we presented crime awareness briefings for 90 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 228 responded. We shared summarized 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.

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 met selected requirements within its QM program.[a]

We conversed with 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 NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

NM	Areas Reviewed	Findings
	There was a senior-level committee/group responsible for QM/performance improvement that met regularly. • There was evidence that outlier data was acted upon. • There was evidence that QM, patient safety, and systems redesign were integrated.	
	The protected peer review process met selected requirements: • The PRC was chaired by the Chief of Staff and included membership by applicable service chiefs. • Actions from individual peer reviews were completed and reported to the PRC. • The PRC submitted quarterly summary reports to the MEC. • Unusual findings or patterns were discussed at the MEC.	
	Focused Professional Practice Evaluations for newly hired licensed independent practitioners were initiated and completed, and results were reported to the MEC.	
X	Specific telemedicine services met selected requirements: • Services were properly approved. • Services were provided and/or received by appropriately privileged staff. • Professional practice evaluation information was available for review.	Twelve months of MEC meeting minutes reviewed: • There was no evidence that the MEC had approved the use of telemedicine technology for teledermatology services.

NM	Areas Reviewed (continued)	Findings
	Observation bed use met selected requirements: • Local policy included necessary elements. • Data regarding appropriateness of observation bed usage was gathered. • If conversions to acute admissions were consistently 30 percent or more, observation criteria and utilization were reassessed timely.	
X	Staff performed continuing stay reviews on at least 75 percent of patients in acute beds.	Twelve months of continuing stay data reviewed: • For 9 months, less than 75 percent of acute inpatients were reviewed.
	The process to review resuscitation events met selected requirements: • An interdisciplinary committee was responsible for reviewing episodes of care where resuscitation was attempted. • Resuscitation event reviews included screening for clinical issues prior to events that may have contributed to the occurrence of the code. • Data were collected that measured performance in responding to events.	
	The surgical review process met selected requirements: • An interdisciplinary committee with appropriate leadership and clinical membership met monthly to review surgical processes and outcomes. • Surgical deaths with identified problems or opportunities for improvement were reviewed. • Additional data elements were routinely reviewed.	
	Critical incidents reporting processes were appropriate.	
X	The process to review the quality of entries in the EHR met selected requirements: • A committee was responsible to review EHR quality. • Data were collected and analyzed at least quarterly. • Reviews included data from most services and program areas.	• There was no evidence that the quality of entries in the EHR was reviewed.
	The policy for scanning non-VA care documents met selected requirements.	

NM	Areas Reviewed (continued)	Findings
X	The process to review blood/transfusions usage met selected requirements: • A committee with appropriate clinical membership met at least quarterly to review blood/transfusions usage. • Additional data elements were routinely reviewed.	Twelve months of Blood Usage Review Committee meeting minutes reviewed: • The clinical representative from Anesthesia Service attended only two of four meetings.
	Overall, if significant issues were identified, actions were taken and evaluated for effectiveness.	
	Overall, 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 met any additional elements required by VHA or local policy.	

Recommendations

1. We recommended that the Medical Executive Committee discuss and document its approval of the use of another facility's providers for teledermatology services.

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

3. We recommended that processes be strengthened to ensure that the quality of entries in the electronic health record is reviewed.

4. We recommended that processes be strengthened to ensure that the Blood Usage Review Committee member from Anesthesia Service consistently attends meetings.

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 and whether the facility met selected requirements in SDS, the PACU, and the eye clinic.[b]

We inspected the intensive care unit, two medical/surgical units, the MH unit, the ED, the CLC, SDS, the operating room, and the PACU. Additionally, we reviewed relevant documents, conversed with key employees and managers, and reviewed 19 employee training records (4 SDS, 10 operating room, and 5 PACU). The table below shows the areas reviewed for this topic. The areas marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

NM	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.	
	An infection prevention risk assessment was conducted, and 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.	
	Fire safety requirements were met.	
X	Environmental safety requirements were met.	• We did not find nurse call systems in one of six patient care areas.
	Infection prevention requirements were met.	
X	Medication safety and security requirements were met.	• We found open, expired multi-dose medication vials in two of six patient care areas.
	Auditory privacy requirements were met.	
	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.	
	Areas Reviewed for SDS and the PACU	
	Designated SDS and PACU employees received bloodborne pathogens training during the past 12 months.	
	Designated SDS employees received medical laser safety training with the frequency required by local policy.	
	Fire safety requirements in SDS and on the PACU were met.	
	Environmental safety requirements in SDS and on the PACU were met.	

NM	Areas Reviewed for SDS and the PACU (continued)	Findings
	SDS medical laser safety requirements were met.	
	Infection prevention requirements in SDS and on the PACU were met.	
X	Medication safety and security requirements in SDS and on the PACU were met.	• We found an open, unlabeled multi-dose medication vial in one of two patient care areas.
	Auditory privacy requirements in SDS and on the PACU were met.	
	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.	
	Areas Reviewed for Eye Clinic	
NA	Designated eye clinic employees received laser safety training with the frequency required by local policy.	
NA	Environmental safety requirements in the eye clinic were met.	
NA	Infection prevention requirements in the eye clinic were met.	
NA	Medication safety and security requirements in the eye clinic were met.	
NA	Laser safety requirements in the eye clinic were met.	
NA	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.	

Recommendations

5. We recommended that nurse call systems be installed in the emergency department.

6. We recommended that processes be strengthened to ensure that multi-dose medication vials are dated when opened and expired medications are promptly removed from patient care areas and that compliance be monitored.

Medication Management

The purpose of this review was to determine whether the appropriate clinical oversight and education were provided to patients discharged with orders for fluoroquinolone oral antibiotics.[c]

We reviewed relevant documents and conversed with key managers and employees. Additionally, we reviewed the EHRs of 32 randomly selected inpatients discharged on 1 of 3 selected oral antibiotics. The table below shows the areas reviewed for this topic. Any items that did not apply to this facility are marked NA. The facility generally met requirements. We made no recommendations.

NM	Areas Reviewed	Findings
	Clinicians conducted inpatient learning assessments within 24 hours of admission or earlier if required by local policy.	
	If learning barriers were identified as part of the learning assessment, medication counseling was adjusted to accommodate the barrier(s).	
	Patient renal function was considered in fluoroquinolone dosage and frequency.	
	Providers completed discharge progress notes or discharge instructions, written instructions were provided to patients/caregivers, and EHR documentation reflected that the instructions were understood.	
	Patients/caregivers were provided a written medication list at discharge, and the information was consistent with the dosage and frequency ordered.	
	Patients/caregivers were offered medication counseling, and this was documented in patient EHRs.	
	The facility established a process for patients/caregivers regarding whom to notify in the event of an adverse medication event.	
	The facility complied with any additional elements required by VHA or local policy.	

Coordination of Care

The purpose of this review was to evaluate discharge planning for patients with selected aftercare needs.[d]

We reviewed relevant documents and conversed with key employees. Additionally, we reviewed the EHRs of two patients with specific diagnoses who were discharged from July 1, 2012, through June 30, 2013. The table below shows the areas reviewed for this topic. Any items that did not apply to this facility are marked NA. The facility generally met requirements. We made no recommendations.

NM	Areas Reviewed	Findings
	Patients' post-discharge needs were identified, and discharge planning addressed the identified needs.	
	Clinicians provided discharge instructions to patients and/or caregivers and validated their understanding.	
	Patients received the ordered aftercare services and/or items within the ordered/expected timeframe.	
	Patients' and/or caregivers' knowledge and learning abilities were assessed during the inpatient stay.	
	The facility complied with any additional elements required by VHA or local policy.	

AIS Care

The purpose of this review was to determine whether the facility complied with selected requirements for the assessment and treatment of patients who had an AIS.[e]

We reviewed relevant documents and the EHRs of 12 patients who experienced stroke symptoms, and we conversed with key employees. We also conducted onsite inspections of the ED, one critical care unit, and four inpatient units. The table below shows the areas reviewed for this topic. The areas marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

NM	Areas Reviewed	Findings
X	The facility's stroke policy/plan/guideline addressed all required items.	• The facility did not have a policy in place addressing the management of AIS.
X	Clinicians completed the National Institutes of Health stroke scale for each patient within the expected timeframe.	• None of the EHRs contained documented evidence of completed stroke scales.
NA	Clinicians provided medication (tPA) timely to halt the stroke and included all required steps, and tPA was in stock or available within 15 minutes.	
X	Stroke guidelines were posted in all areas where patients may present with stroke symptoms.	• Stroke guidelines were not posted in the ED or on any of the five units.
X	Clinicians screened patients for difficulty swallowing prior to oral intake of food or medicine.	• Five of the 11 applicable EHRs did not contain documentation that patients were screened for difficulty swallowing prior to oral intake.
X	Clinicians provided printed stroke education to patients upon discharge.	• Eight of the 10 applicable EHRs did not contain documentation that stroke education was provided to the patient/caregiver.
NA	The facility provided training to staff involved in assessing and treating stroke patients.	
X	The facility collected and reported required data related to stroke care.	• There was no evidence that the following data were collected and/or reported to VHA: o Percent of eligible patients given tPA o Percent of patients with stroke symptoms who had the stroke scale completed o Percent of patients screened for difficulty swallowing before oral intake.
	The facility complied with any additional elements required by VHA or local policy.	

Recommendations

7. We recommended that the facility develop an acute ischemic stroke policy that addresses all required items, that the policy be fully implemented, and that compliance be monitored.

8. We recommended that processes be strengthened to ensure that clinicians complete and document National Institutes of Health stroke scales for each stroke patient and that compliance be monitored.

9. We recommended that stroke guidelines be posted in the emergency department, on the critical care unit, and on all inpatient units.

10. We recommended that processes be strengthened to ensure that clinicians screen patients for difficulty swallowing prior to oral intake.

11. We recommended that processes be strengthened to ensure that clinicians provide printed stroke education to patients upon discharge and that compliance be monitored.

12. We recommended that the facility collect and report to VHA the percent of eligible patients given tissue plasminogen activator, the percent of patients with stroke symptoms who had the stroke scale completed, and the percent of patients screened for difficulty swallowing before oral intake.

CLC Resident Independence and Dignity

The purpose of this review was to determine whether the facility provided CLC restorative nursing services and complied with selected nutritional management and dining service requirements to assist CLC residents in maintaining their optimal level of functioning, independence, and dignity.[f]

We reviewed six EHRs of residents (five residents receiving restorative nursing services and one resident not receiving restorative nursing services but a candidate for services). We also observed one resident during two meal periods, reviewed two employee training/competency records and other relevant documents, and conversed with key employees. The table below shows the areas reviewed for this topic. The area marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

NM	Areas Reviewed	Findings
	The facility offered restorative nursing services.	
	Facility staff completed and documented restorative nursing services, including active and passive range of motion, bed mobility, transfer, and walking activities, according to clinician orders and residents' care plans.	
	Resident progress towards restorative nursing goals was documented, and interventions were modified as needed to promote the resident's accomplishment of goals.	
	When restorative nursing services were care planned but were not provided or were discontinued, reasons were documented in the EHR.	
	If residents were discharged from physical therapy, occupational therapy, or kinesiotherapy, there was hand-off communication between Physical Medicine and Rehabilitation Service and the CLC to ensure that restorative nursing services occurred.	
	Training and competency assessment were completed for staff who performed restorative nursing services.	
X	The facility complied with any additional elements required by VHA or local policy.	Facility policy on CLC Restorative Nursing Program reviewed: • The Restorative Care Coordinator did not consistently document patient restorative program goals and progress weekly in any of the five applicable EHRs.

NM	Areas Reviewed for Assistive Eating Devices and Dining Service	Findings
	Care planned/ordered assistive eating devices were provided to residents at meal times.	
	Required activities were performed during resident meal periods.	
	The facility complied with any additional elements required by VHA or local policy.	

Recommendation

13. We recommended that processes be strengthened to ensure that the Restorative Care Coordinator documents patient restorative program goals and progress weekly in accordance with facility policy and that compliance be monitored.

MRI Safety

The purpose of this review was to determine whether the facility ensured safety in MRI in accordance with VHA policy requirements related to: (1) staff safety training, (2) patient screening, and (3) risk assessment of the MRI environment.[g]

We reviewed relevant documents and the training records of 32 employees (28 randomly selected Level 1 ancillary staff and 4 designated Level 2 MRI personnel), and we conversed with key managers and employees. We also reviewed the EHRs of 35 randomly selected patients who had an MRI January 1–December 31, 2013. Additionally, we conducted a physical inspection of one MRI area. The table below shows the areas reviewed for this topic. The area marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

NM	Areas Reviewed	Findings
	The facility completed an MRI risk assessment, there were documented procedures for handling emergencies in MRI, and emergency drills were conducted in the MRI area.	
X	Two patient safety screenings were conducted prior to MRI, and the secondary patient safety screening form was signed by the patient, family member, or caregiver and reviewed and signed by a Level 2 MRI personnel.	• None of the EHRs contained initial patient safety screenings. • Thirty-three EHRs (94 percent) did not contain secondary patient safety screenings prior to MRI; therefore, we were unable to determine whether any contraindications were addressed. • Neither of the two secondary patient safety screening forms were signed by a Level 2 MRI personnel prior to MRI.
	Any MRI contraindications were noted on the secondary patient safety screening form, and a Level 2 MRI personnel and/or radiologist addressed the contraindications and documented resolution prior to MRI.	
	Level 1 ancillary staff and Level 2 MRI personnel were designated and received level-specific annual MRI safety training.	
	Signage and barriers were in place to prevent unauthorized or accidental access to Zones III and IV.	
	MRI technologists maintained visual contact with patients in the magnet room and two-way communication with patients inside the magnet, and the two-way communication device was regularly tested.	
	Patients were offered MRI-safe hearing protection for use during the scan.	

NM	Areas Reviewed (continued)	Findings
	The facility had only MRI-safe or compatible equipment in Zones III and IV, or the equipment was appropriately protected from the magnet.	
	The facility complied with any additional elements required by VHA or local policy.	

Recommendations

14. We recommended that processes be strengthened to ensure that initial patient safety screenings are conducted and documented in patients' electronic health records and that compliance be monitored.

15. We recommended that processes be strengthened to ensure that secondary patient safety screenings are completed immediately prior to magnetic resonance imaging and placed in patients' electronic health records, that any contraindications are identified and resolution documented prior to the scan, that Level 2 personnel conducting the secondary screenings sign the forms prior to the scan, and that compliance be monitored.

Review Activity with Previous CAP Recommendations

Follow-Up on CRC Screening

As a follow-up to recommendations from our previous CAP review, we attempted to reassess facility compliance with CRC screening;[h] however, the facility was unable to provide evidence of sustained compliance for any of the requirements below.

Positive CRC Screening Test Result Notification. VHA requires that patients receive notification of CRC screening test results within 14 days of the laboratory receipt date for fecal occult blood tests or the test date for sigmoidoscopy or double contrast barium enema and that clinicians document notification.

Follow-Up in Response to Positive CRC Screening Test. For any positive CRC screening test, VHA requires responsible clinicians to either document a follow-up plan or document that no follow-up is indicated within 14 days of the screening test.

Diagnostic Testing Timeliness. VHA requires that patients receive diagnostic testing within 60 days of positive CRC screening test results unless contraindicated.

Diagnostic Test Result Notification. VHA requires that test results be communicated to patients no later than 14 days from the date on which the results are available to the ordering practitioner and that clinicians document notification.

Biopsy Result Notification. VHA requires that patients who have a biopsy receive notification within 14 days of the date the biopsy results were confirmed and that clinicians document notification.

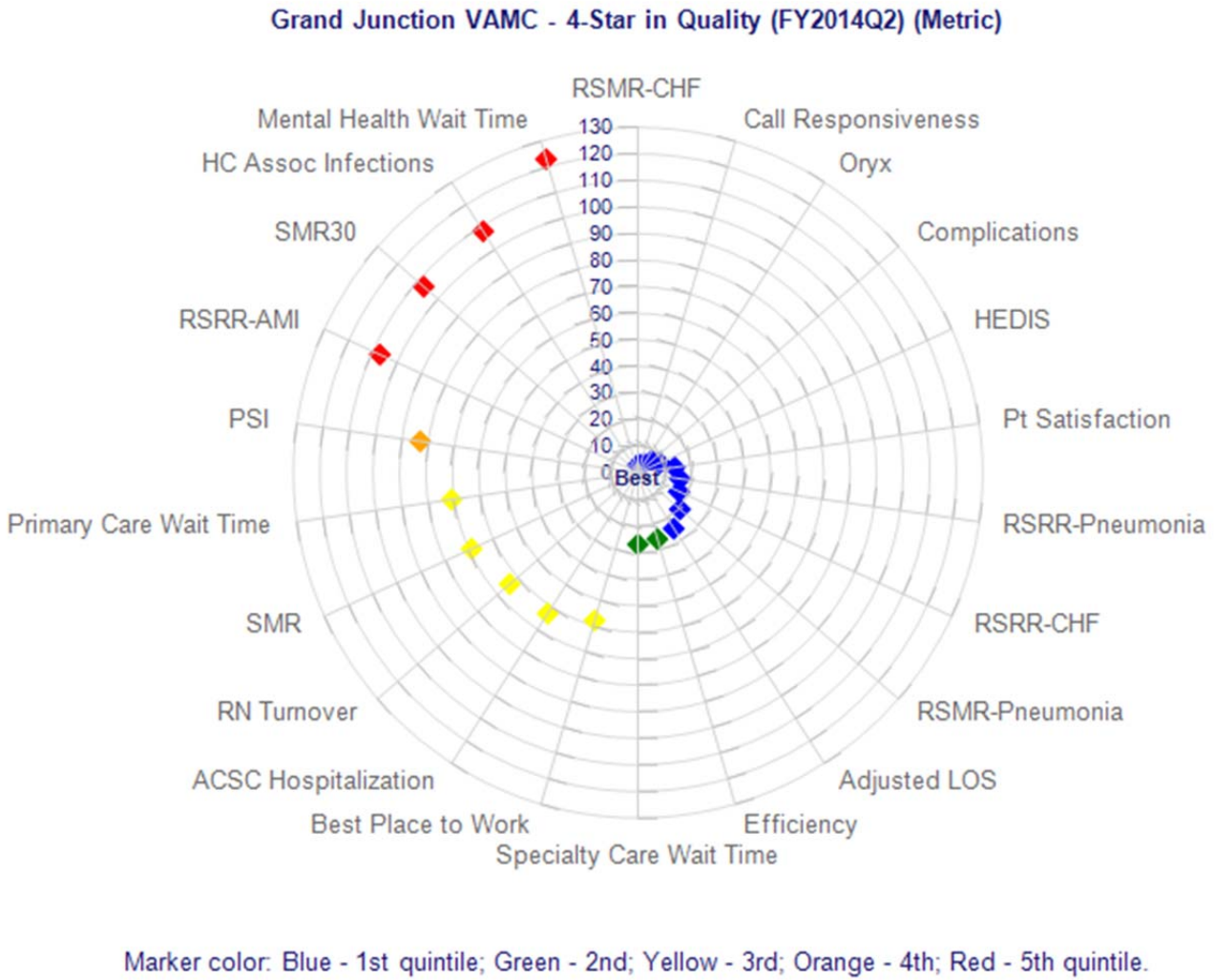
Recommendation

16. We recommended that the facility implement processes to monitor compliance with colorectal cancer timeliness and patient notification requirements.

Facility Profile (Grand Junction/575) FY 2014 through June 2014[1]	
Type of Organization	Secondary
Complexity Level	2-Medium complexity
Affiliated/Non-Affiliated	Affiliated
Total Medical Care Budget in Millions	$98.9
Number (as of July 2014) of:	
• **Unique Patients**	13,046
• **Outpatient Visits**	143,021
• **Unique Employees**[2]	501
Type and Number of Operating Beds:	
• **Hospital**	31
• **CLC**	30
• **MH**	NA
Average Daily Census:	
• **Hospital**	17
• **CLC**	25
• **MH**	NA
Number of Community Based Outpatient Clinics	2
Location(s)/Station Number(s)	Montrose/575GA Craig/575GB
VISN Number	19

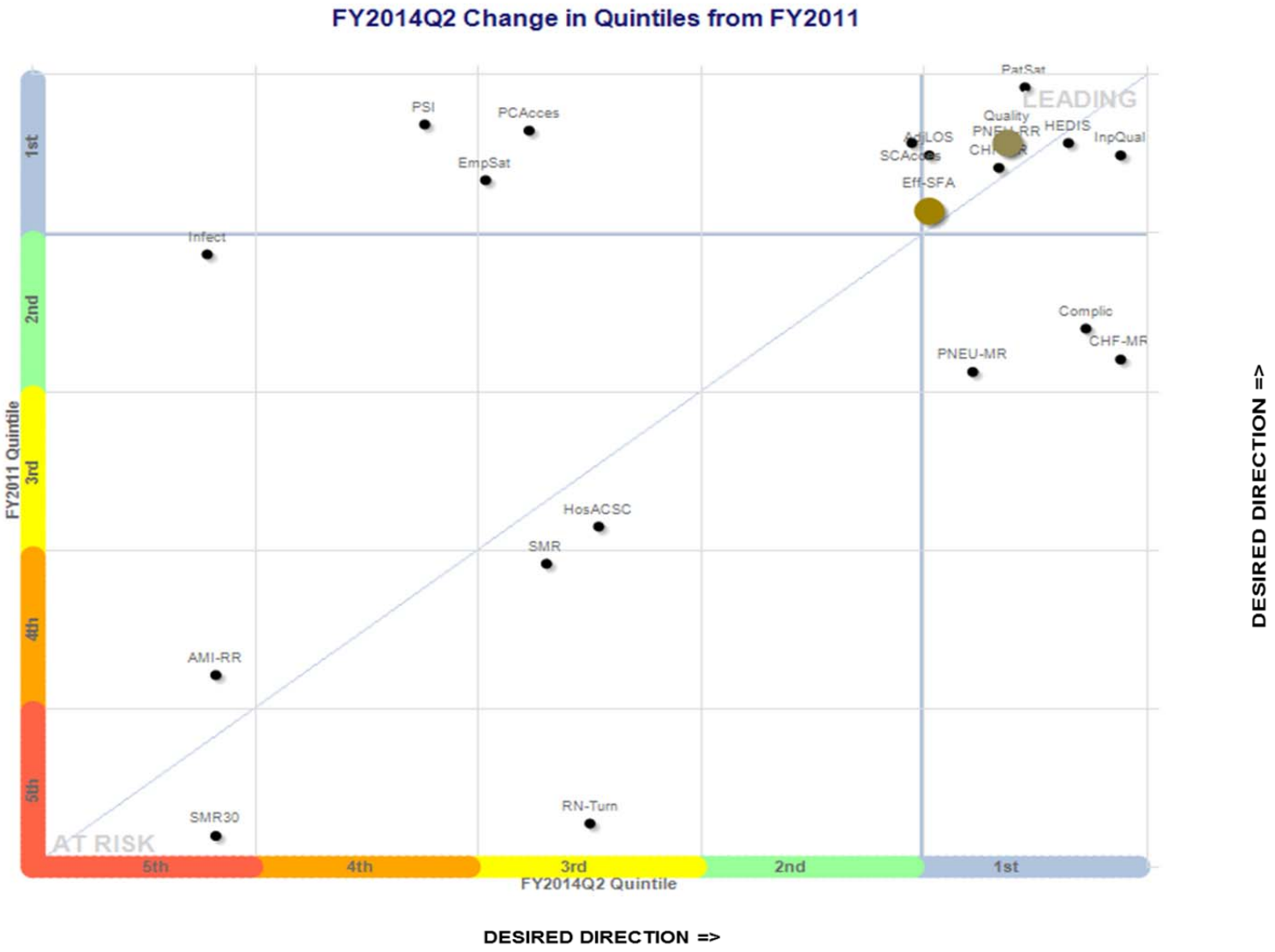
[1] All data is for FY 2014 through June 2014 except where noted.
[2] Unique employees involved in direct medical care (cost center 8200).

Strategic Analytics for Improvement and Learning (SAIL)[3]



[3] Metric definitions follow the graphs.

Scatter Chart



NOTE

Quintiles are derived from facility ranking on z-score of a metric among 128 facilities. Lower quintile is more favorable.

Metric Definitions

Measure	Definition	Desired direction
ACSC Hospitalization	Ambulatory care sensitive condition hospitalizations (observed to expected ratio)	A lower value is better than a higher value
Adjusted LOS	Acute care risk adjusted length of stay	A lower value is better than a higher value
Best Place to Work	Overall satisfaction with job	A higher value is better than a lower value
Call Center Responsiveness	Average speed of call center responded to calls in seconds	A lower value is better than a higher value
Call Responsiveness	Call center speed in picking up calls and telephone abandonment rate	A lower value is better than a higher value
Complications	Acute care risk adjusted complication ratio	A lower value is better than a higher value
Efficiency	Overall efficiency measured as 1 divided by SFA (Stochastic Frontier Analysis)	A higher value is better than a lower value
Employee Satisfaction	Overall satisfaction with job	A higher value is better than a lower value
HC Assoc Infections	Health care associated infections	A lower value is better than a higher value
HEDIS	Outpatient performance measure (HEDIS)	A higher value is better than a lower value
MH Status	MH status (outpatient only, the Veterans RAND 12 Item Health Survey)	A higher value is better than a lower value
MH Wait Time	MH wait time for new and established patients (top 50 clinics; FY13 and later)	A higher value is better than a lower value
Oryx	Inpatient performance measure (ORYX)	A higher value is better than a lower value
Physical Health Status	Physical health status (outpatient only, the Veterans RAND 12 item Health Survey)	A higher value is better than a lower value
Primary Care Wait Time	Primary care wait time for new and established patients (top 50 clinics; FY13 and later)	A higher value is better than a lower value
PSI	Patient safety indicator (observed to expected ratio)	A lower value is better than a higher value
Pt Satisfaction	Overall rating of hospital stay (inpatient only)	A higher value is better than a lower value
RN Turnover	Registered nurse turnover rate	A lower value is better than a higher value
RSMR-AMI	30-day risk standardized mortality rate for acute myocardial infarction	A lower value is better than a higher value
RSMR-CHF	30-day risk standardized mortality rate for congestive heart failure	A lower value is better than a higher value
RSMR-Pneumonia	30-day risk standardized mortality rate for pneumonia	A lower value is better than a higher value
RSRR-AMI	30-day risk standardized readmission rate for acute myocardial infarction	A lower value is better than a higher value
RSRR-CHF	30-day risk standardized readmission rate for congestive heart failure	A lower value is better than a higher value
RSRR-Pneumonia	30-day risk standardized readmission rate for pneumonia	A lower value is better than a higher value
SMR	Acute care in-hospital standardized mortality ratio	A lower value is better than a higher value
SMR30	Acute care 30-day standardized mortality ratio	A lower value is better than a higher value
Specialty Care Wait Time	Specialty care wait time for new and established patients (top 50 clinics; FY13 and later)	A higher value is better than a lower value

Acting VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: August 15, 2014

From: Acting Director, Rocky Mountain Network (10N19)

Subject: **CAP Review of the Grand Junction VA Medical Center, Grand Junction, CO**

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

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

I have reviewed and concur on the submitted responses to the Grand Junction VAMC OIG CAP Draft Report. If you have any further questions please contact Ms. Susan Curtis, VISN 19 HSS (303) 639-6995.

Leigh Anderson, VISN 19 Chief Medical Officer
Signed for and in the absence of:
Ralph T. Gigliotti, FACHE
Director, Rocky Mountain Network (10N19)

Facility Director Comments

Department of Veterans Affairs **Memorandum**

Date: August 11, 2014

From: Director, Grand Junction VA Medical Center (575/00)

Subject: **CAP Review of the Grand Junction VA Medical Center, Grand Junction, CO**

To: Director, Rocky Mountain Network (10N19)

1. Thank you for the opportunity to submit responses to the proposed recommendations for the Grand Junction VA Medical Center, Grand Junction, CO.

2. I have reviewed and concur with the sixteen (16) findings and recommendations in the report of the Office of Inspector General conducted the week of July 7, 2014.

3. Corrective action plans and compliance monitoring have been established and target completion dates have been set for the recommendations as detailed in the attached report.

4. If you have additional questions or need further information, please contact Michelle Ernzen, Chief, Quality Management, at (970) 242-0731, x2873.

MARC A MAGILL, M.S.
Medical Center Director

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 the Medical Executive Committee discuss and document its approval of the use of another facility's providers for teledermatology services.

Concur

Target date for completion: October 31, 2014

Facility response: The teledermatology service agreement will be discussed at the September Clinical Executive Board meeting. Discussions and approval of services will be documented in the meeting minutes.

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

Concur

Target date for completion: October 31, 2014

Facility response: The facility hired and trained a Quality Management Specialist (January 2014) who has primary responsibilities for performing and communicating continued stay reviews. Additionally, another QM Specialist has been trained to complete the reviews, thus providing continued coverage during planned and unplanned absences. Since March 2014, the facility has achieved >95% compliance on the continued stay reviews. Compliance monitoring will occur quarterly through the UM report to the Clinical Executive Board.

Recommendation 3. We recommended that processes be strengthened to ensure that the quality of entries in the electronic health record is reviewed.

Concur

Target date for completion: June 30, 2015

Facility response: Service Chiefs, Supervisors, and Administrative Officers received training on the process for performing quality record reviews and reporting requirements to the Medical Record Committee. Quality Management developed and distributed a Microsoft Excel workbook to aid services in compiling and reporting the quality record reviews to the committee. The Medical Record Committee will develop and distribute a

reporting grid that outlines when services are scheduled to report their quality record reviews to the committee. Quality data not meeting the identified performance standard will require action plans for submission to committee for review and analysis. Compliance will be monitored through the Medical Record Committee.

Recommendation 4. We recommended that processes be strengthened to ensure that the Blood Usage Review Committee member from Anesthesia Service consistently attends meetings.

Concur

Target date for completion: December 31, 2014

Facility response: The Section Chief, Anesthesia, has been assigned as the permanent member of the Blood Utilization Committee. During his absence, another Anesthesia provider will attend the meetings.

Recommendation 5. We recommended that nurse call systems be installed in the emergency department.

Concur

Target date for completion: June 30, 2015

Facility response: GJVAMC concurs with the recommendation to install a nurse call system in the Emergency Department. By December 31, 2014, a request for funding will be uploaded to the VISN 19 Capital Asset Manager (CAM) for the design and installation of the nurse call systems. Award of the project is expected by March 31, 2015. Interim measures are in place and include bedside hand bells and increased staff presence.

Recommendation 6. We recommended that processes be strengthened to ensure that multi-dose medication vials are dated when opened and expired medications are promptly removed from patient care areas and that compliance be monitored.

Concur

Target date for completion: December 31, 2014

Facility response: By August 31, 2014, the Medication Management Policy (MCM 119-3) will be revised to reflect the need for expired medications to be promptly removed from patient care areas. Patient Care Services staff will be re-educated on the policy and procedures required for safe medication management by September 30, 2014. Additionally, the expiration date review has been added to the "Daily Checklist" for all patient care areas, and as a result, all MDV will be checked for expiration on a daily basis (on days the unit is open; i.e. Outpatient Clinics that work Monday–Friday will not have the checklist completed on weekends, as there are no patients or staff in those areas during the weekend). The Associate Chief Nurse

(ACNS) assigned to each unit will be responsible for monitoring compliance via review of the Daily Checklists. Compliance will also be monitored during EOC rounds.

Recommendation 7. We recommended that the facility develop an acute ischemic stroke policy that addresses all required items, that the policy be fully implemented, and that compliance be monitored.

Concur

Target date for completion: December 31, 2014

Facility response: A small interdisciplinary team has been formed and is developing a policy defining the treatment of Acute Ischemic Stroke (AIS) for a Supporting Stroke Facility as required by VHA Directive by September 30, 2014. Education of staff will be completed by October 31, 2014. Compliance monitoring will be accomplished through the AIS quality indicator monitoring and reported quarterly to the Critical Care Committee.

Recommendation 8. We recommended that processes be strengthened to ensure that clinicians complete and document National Institutes of Health stroke scales for each stroke patient and that compliance be monitored.

Concur

Target date for completion: March 31, 2015

Facility response: An NIH template note is being developed for documentation of the NIH stroke scale. The note will be free-standing for clinical staff to complete when indicated and will be incorporated into the Emergency Department triage note. The template note and staff training will occur by October 31, 2014. Compliance monitoring of the use of the NIH stroke scale will be accomplished through the AIS quality indicator monitoring and reported to the Critical Care Committee.

Recommendation 9. We recommended that stroke guidelines be posted in the emergency department, on the critical care unit, and on all inpatient units.

Concur

Target date for completion: October 31, 2014

Facility response: Stroke guidelines for recognition and treatment of AIS will be posted in the outpatient clinics, inpatient wards, Community Living Center, and the Emergency Department by October 31, 2014. In addition, stroke guideline badge buddies have been ordered and will be distributed to clinical staff.

Recommendation 10. We recommended that processes be strengthened to ensure that clinicians screen patients for difficulty swallowing prior to oral intake.

Concur

Target date for completion: March 31, 2015

Facility response: Nursing Patient Care Memorandum 003-50, Stroke Patient Nursing Swallow Screen has been in place since March 2013. Nursing staff will be re-educated on the dysphagia screening by October 31, 2014. Compliance monitoring of the dysphagia screening will be accomplished through the AIS quality indicator monitoring and reported to the Critical Care Committee.

Recommendation 11. We recommended that processes be strengthened to ensure that clinicians provide printed stroke education to patients upon discharge and that compliance be monitored.

Concur

Target date for completion: March 31, 2015

Facility response: Education Service will identify select stroke education materials that will be available for Veterans. Educational material will be added to the tools section in CPRS so staff can print and provide to patients on discharge. Reminder dialogue will be added to the Education Note for staff to document the specific handout that was provided to the Veteran/Caregiver. Training of staff will occur by October 31, 2014. Compliance monitoring of documentation of printed materials will be accomplished through the AIS quality indicator monitoring process and reported to the Critical Care Committee.

Recommendation 12. We recommended that the facility collect and report to VHA the percent of eligible patients given tissue plasminogen activator, the percent of patients with stroke symptoms who had the stroke scale completed, and the percent of patients screened for difficulty swallowing before oral intake.

Concur

Target date for completion: December 31, 2014

Facility response: A QM Specialist has been identified to collect and report Acute Ischemic Stroke quality indicators. Training on the quality indicator data collection and data analysis will occur by September 30, 2014. Quality indicator data will be presented quarterly to the Critical Care Committee (CCC). Discussion and recommended improvement actions will be documented in the CCC minutes.

Recommendation 13. We recommended that processes be strengthened to ensure that the Restorative Care Coordinator documents patient restorative program goals and progress weekly in accordance with facility policy and that compliance be monitored.

Concur

Target date for completion: January 31, 2015

Facility response: The unit specific memorandum (USM) 003T-24, Community Living Center Restorative Nursing Program, will be revised to reflect a monthly assessment of the restorative goals that is documented in CPRS. The USM changes will be completed by September 30, 2014. The Restorative Care Nurse will be placed on the work schedule for administrative time for a minimum of 4–8 hours a month to complete documentation and any other administrative duties for the Restorative Care program. Monthly compliance monitoring will be done by the Associate Chief Nurse and reported to the CLC Steering Committee.

Recommendation 14. We recommended that processes be strengthened to ensure that initial patient safety screenings are conducted and documented in patients' electronic health records and that compliance be monitored.

Concur

Target date for completion: December 31, 2014

Facility response: MRI primary and secondary patient safety screens are on the same piece of paper. Primary screen will be completed by the radiology scheduler at the time MRI is scheduled. Education has been completed with staff regarding the necessity for legible full signature (first and last name) and date. Signature requirements include both staff members and patient/caregiver. Provider order sets for MRI ordering will be changed to include primary safety screening questions. Radiology Supervisor will do a 100% review of safety screens beginning July 1, 2014, and continuing through the end of September 2014. Following the end of the 90 day 100% review, the Radiology Supervisor will do random audits and report results to the MRI Safety Committee on a quarterly basis.

Recommendation 15. We recommended that processes be strengthened to ensure that secondary patient safety screenings are completed immediately prior to magnetic resonance imaging and placed in patients' electronic health records, that any contraindications are identified and resolution documented prior to the scan, that Level 2 personnel conducting the secondary screenings sign the forms prior to the scan, and that compliance be monitored.

Concur

Target date for completion: December 31, 2014

Facility response: Secondary screen will be completed by the MRI Tech on the same day of the scan immediately prior to beginning the scan. Education has been completed with staff regarding the necessity for legible full signature (first and last name) and date. Signature requirements include both staff members and patient/caregiver. Radiologist, Radiology Supervisor and Clinic Application Coordinator will develop CPRS changes to assist with the identification and resolution of contraindications identified on the safety screen. These changes will be put into place by August 31, 2014, and include: MRI contraindications note title in CPRS, to be used by the Radiologist and/or Level 2 MRI personnel for documenting contraindications and resolution. Radiology Supervisor will run a quarterly list of "contraindication note titles" and audit those charts for resolution and appropriate documentation. Results will be reported to the MRI Safety Committee on a quarterly basis.

Recommendation 16. We recommended that the facility implement processes to monitor compliance with colorectal cancer timeliness and patient notification requirements.

Concur

Target date for completion: December 31, 2014

Facility response: The Endoscopy Nurse role has been modified to a Case Management model. The Endoscopy Nurse is responsible for monitoring all aspects of the colorectal cancer screening process for all FOBT+ Veterans and communicating with providers as indicated. Tracking of all FOBT+ Veterans started in July 2014. Primary Care and Surgery providers will be educated on documentation of patient notification of test results and follow up plan by September 30, 2014. Compliance monitoring will be done by the Endoscopy Nurse and reported quarterly to the Invasive/Operative Committee.

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Endnotes

[a] References used for this topic included:
- VHA Directive 2009-043, *Quality Management System*, September 11, 2009.
- VHA Handbook 1050.01, *VHA National Patient Safety Improvement Handbook*, March 4, 2011.
- VHA Directive 2010-017, *Prevention of Retained Surgical Items*, April 12, 2010.
- VHA Directive 2010-025, *Peer Review for Quality Management*, June 3, 2010.
- VHA Directive 2010-011, *Standards for Emergency Departments, Urgent Care Clinics, and Facility Observation Beds*, March 4, 2010.
- VHA Directive 2009-064, *Recording Observation Patients*, November 30, 2009.
- VHA Handbook 1100.19, *Credentialing and Privileging*, October 15, 2012.
- VHA Directive 2008-063, *Oversight and Monitoring of Cardiopulmonary Resuscitative Events and Facility Cardiopulmonary Resuscitation Committees*, October 17, 2008.
- VHA Handbook 1907.01, *Health Information Management and Health Records*, September 19, 2012.
- VHA Directive 6300, *Records Management*, July 10, 2012.
- VHA Directive 2009-005, *Transfusion Utilization Committee and Program*, February 9, 2009.
- VHA Handbook 1106.01, *Pathology and Laboratory Medicine Service Procedures*, October 6, 2008.

[b] References used for this topic included:
- VHA Directive 2011-007, *Required Hand Hygiene Practices*, February 16, 2011.
- VHA Handbook 1121.01, *VHA Eye Care*, March 10, 2011.
- VA National Center for Patient Safety, "Multi-Dose Pen Injectors," Patient Safety Alert 13-04, January 17, 2013.
- "Adenovirus-Associated Epidemic Keratoconjunctivitis Outbreaks –Four States, 2008–2010," Centers for Disease Control and Prevention Morbidity and Mortality Weekly Report, August 16, 2013.
- Various requirements of The Joint Commission, the Occupational Safety and Health Administration, the American National Standards Institute/Advancing Safety in Medical Technology, the Centers for Disease Control and Prevention, the International Association of Healthcare Central Service Materiel Management ,the National Fire Protection Association, the Health Insurance Portability and Accountability Act, Underwriters Laboratories.

[c] References used for this topic included:
- VHA Handbook 1108.06, *Inpatient Pharmacy Services*, June 27, 2006.
- VHA Handbook 1108.05, *Outpatient Pharmacy Services*, May 30, 2006.
- VHA Directive 2011-012, *Medication Reconciliation*, March 9, 2011.
- VHA Handbook 1907.01, *Health Information Management and Health Records*, September 19, 2012.
- Manufacturer's instructions for Cipro® and Levaquin®.
- Various requirements of The Joint Commission.

[d] References used for this topic included:
- VHA Handbook 1120.04, *Veterans Health Education and Information Core Program Requirements*, July 29, 2009.
- VHA Handbook 1907.01, *Health Information Management and Health Records*, September 19, 2012.
- The Joint Commission, *Comprehensive Accreditation Manual for Hospitals*, July 2013.

[e] The references used for this topic were:
- VHA Directive 2011-038, Treatment of Acute Ischemic Stroke, November 2, 2011.
- Guidelines for the Early Management of Patients with Acute Ischemic Stroke (AHA/ASA Guidelines), January 31, 2013.

[f] References used for this topic included:
- VHA Handbook 1142.01, *Criteria and Standards for VA Community Living Centers (CLC)*, August 13, 2008.
- VHA Handbook 1142.03, *Requirements for Use of the Resident Assessment Instrument (RAI) Minimum Data Set (MDS)*, January 4, 2013.
- Centers for Medicare and Medicaid Services, *Long-Term Care Facility Resident Assessment Instrument User's Manual*, Version 3.0, May 2013.
- VHA Manual M-2, Part VIII, Chapter 1, *Physical Medicine and Rehabilitation Service*, October 7, 1992.
- Various requirements of The Joint Commission.

[g] References used for this topic included:
- VHA Handbook 1105.05, *Magnetic Resonance Imaging Safety*, July 19, 2012.
- Emanuel Kanal, MD, et al., "ACR Guidance Document on MR Safe Practices: 2013," *Journal of Magnetic Resonance Imaging*, Vol. 37, No. 3, January 23, 2013, pp. 501–530.
- The Joint Commission, "Preventing accidents and injuries in the MRI suite," Sentinel Event Alert, Issue 38, February 14, 2008.
- VA National Center for Patient Safety, "MR Hazard Summary," http://www.patientsafety.va.gov/professionals/hazards/mr.asp.
- VA Radiology, "Online Guide," http://vaww1.va.gov/RADIOLOGY/OnLine_Guide.asp, updated October 4, 2011.

[h] The references used for this topic were:
- VHA Directive 2007-004, *Colorectal Cancer Screening*, January 12, 2007 (corrected copy).
- VHA Directive 2009-019, *Ordering and Reporting Test Results*, March 24, 2009.