Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 11-02078-290

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

September 27, 2011

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

ACLS	Advanced Cardiac Life Support
AD	advance directive
C&P	credentialing and privileging
CAP	Combined Assessment Program
CLC	community living center
ED	emergency department
EN	enteral nutrition
EOC	environment of care
facility	Lexington VA Medical Center
FY	fiscal year
MEC	Medical Executive Committee
OIG	Office of Inspector General
OPPE	Ongoing Professional Practice Evaluation
PR	peer review
PTSD	post-traumatic stress disorder
QM	quality management
RRTP	residential rehabilitation treatment program
SA	substance abuse
RN	registered nurse
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

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Executive Summary: Combined Assessment Program Review of the Lexington VA Medical Center, Lexington, KY

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 11, 2011.

Review Results: The review covered eight activities. We made no recommendations in the following activity:

- Medication Management

The facility's reported accomplishment was a reduction in length of stay and days of diversion in the emergency department.

Recommendations: We made recommendations in the following seven activities:

Quality Management: Report peer review findings to the Medical Executive Committee quarterly. Complete peer reviews within 120 days or have extensions. Perform and document pre-sedation risk assessments. Ensure providers who perform moderate sedation have documented evidence of Advanced Cardiac Life Support certification or equivalent training.

Physician Credentialing and Privileging: Collect and maintain meaningful competency data. Ensure the Medical Executive Committee reviews data prior to making reprivileging decisions.

Registered Nurse Competencies: Assess and validate competencies. Take action when competency does not meet expectations, and document actions. Specify the methods used to assess and validate competency.

Environment of Care: Ensure Substance Abuse Residential Rehabilitation Treatment Program staff follow the medication destruction policy. Define a medication disposal protocol for the Post-Traumatic Stress Disorder Residential Rehabilitation Treatment Program, and monitor compliance.

Management of Workplace Violence: Ensure managers comply with facility management of workplace violence policy. Revise the facility training plan.

Enteral Nutrition Safety: Monitor compliance with use of the newly implemented enteral nutrition order set.

Coordination of Care: Provide all components of written advance directive notification to patients, and document notification in the medical record.

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 eight activities:

- Coordination of Care
- EN Safety
- EOC
- Management of Workplace Violence
- Medication Management
- Physician C&P
- QM
- RN Competencies

The review covered facility operations for FY 2010 and FY 2011 through July 11, 2011, and was done in accordance with OIG standard operating procedures for CAP reviews. We also followed up on selected recommendations from our prior CAP review of the facility (*Combined Assessment Program Review of the Lexington VA Medical Center,*

Lexington, Kentucky, Report No. 08-03074-101, March 31, 2009). (See Appendix B for further details.) The facility had repeat findings in the areas of Physician C&P (formerly included in the QM activity) and RN competencies.

During this review, we also presented crime awareness briefings for 160 employees. These briefings covered procedures for reporting suspected criminal activity to the OIG and included case-specific examples illustrating procurement fraud, conflicts of interest, and bribery.

In this report, we make recommendations for improvement. Recommendations pertain to issues that are significant enough to be monitored by the OIG until corrective actions are implemented.

Reported Accomplishment

ED Length of Stay and Diversion

In 2010, the facility initiated a systems redesign project to reduce the time from ED discharge to admission to an inpatient unit thereby increasing access to ED beds. The project's goals were to increase the availability of beds in the ED and to reduce the number of days patients were diverted to community hospitals. The facility implemented methods that improved the efficiency of the inpatient discharge process. This involved assigning utilization case managers to the medical teams to educate providers on utilization management criteria and to facilitate discharge readiness. The systems redesign team also streamlined the referral process for patients admitted to the CLC. As a result, the ED average length of stay deceased from greater than 11 hours between July 2009 and June 2010 to less than 8 hours between June 2010 and June 2011. The days of diversion during the same timeframes decreased from 42 days to 4 days, respectively.

Results

Review Activities With Recommendations

QM

The purpose of this review was to evaluate whether the facility had a comprehensive QM program in accordance with applicable requirements and whether senior managers actively supported the program's activities.

We interviewed senior managers and QM personnel, and we evaluated policies, meeting minutes, and other relevant

documents. We identified the following areas that needed improvement.

PR. VHA requires that PR results be reported to the MEC on a quarterly basis.[1] VHA also requires that facilities complete a PR within 120 days from determination of the need for the review. Any extension beyond 120 days must be requested in writing from and approved by the facility's Director. We found that PR findings were not discussed at the MEC in 3 out of the past 4 quarters. Additionally, eight PRs were not completed within the 120-day timeframe, and no extension requests had been submitted.

Moderate Sedation. VHA requires that a pre-sedation assessment that includes an assessment of risk be performed prior to administration of moderate sedation.[2] We reviewed the medical records of 10 patients who underwent moderate sedation and found that 5 had no documented evidence of risk assessments.

VHA requires providers who perform moderate sedation to be trained in cardiopulmonary resuscitation, airway management, and management of cardiac arrhythmias.[3] This requirement may be satisfied by completing ACLS training or the equivalent. We reviewed the training records of seven non-anesthesia providers who performed moderate sedation in the Cardiac Catheterization Laboratory and found that three had no documented evidence of ACLS or Basic Life Support training.

Recommendations

1. We recommended that PR findings be reported to the MEC quarterly and that PRs are either completed within 120 days or have extensions requested in writing from and approved by the facility's Director.

2. We recommended that processes be strengthened to ensure that pre-sedation risk assessments are consistently performed and documented prior to moderate sedation procedures.

3. We recommended that all non-anesthesia providers who perform moderate sedation have documented evidence of ACLS certification or the equivalent in their training records.

[1] VHA Directive 2010-025, *Peer Review for Quality Management*, June 3, 2010.
[2] VHA Directive 2006-023, *Moderate Sedation by Non-Anesthesia Providers*, May 1, 2006.
[3] VHA Directive 2006-023.

Physician C&P

The purpose of this review was to determine whether the facility had consistent processes for physician C&P that complied with applicable requirements.

We reviewed 15 physicians' C&P files and profiles and found that licenses were current and that primary source verification had been obtained. However, we identified the following area that needed improvement.

OPPE. VHA requires that data consistent with service-specific competency criteria be collected, maintained in each physician's profile, and reviewed on an ongoing periodic basis.[4] We reviewed 10 physician profiles for OPPE. Six of the 10 profiles reviewed did not have evidence of data for the previous 4 quarterly OPPE periods. This was a repeat finding from the previous CAP review.

VHA requires that the MEC review and document clinical competence information prior to reprivileging.[5] Although MEC meeting minutes stated that the committee reviewed OPPE data prior to reprivileging, there was no supporting data for 6 of the 10 physicians whose profiles we reviewed.

Recommendation

4. We recommended that service chiefs collect and maintain meaningful competency data for all providers and that the MEC review actual performance data prior to making reprivileging decisions.

RN Competencies

The purpose of this review was to determine whether the facility had an adequate RN competency assessment and validation process.

We reviewed facility policy, interviewed nurse managers, and reviewed initial and ongoing competency assessment and validation documents for 12 RNs. We identified the following areas that needed improvement.

Facility Competency Validation Process. The Joint Commission requires that clinical staff are deemed competent to perform their job responsibilities and that the facility takes action when staff competency does not meet expectations. While facility policy requires an initial assessment and validation of RN core and unit/position-specific competencies and an annual assessment thereafter, we found that managers did not

[4] VHA Handbook 1100.19, *Credentialing and Privileging*, November 14, 2008.
[5] VHA Handbook 1100.19.

follow the policy. Core and unit/position-specific competencies were not consistently identified, assessed, or validated. Additionally, there was no evidence of actions taken to correct deficiencies.

Competency Validation Documentation. The Joint Commission requires that nursing personnel are competent to perform their responsibilities. Core competencies, such as medication administration, are skills required for all RNs. Unit/position competencies are specific to a particular area of patient care, such as an intensive care unit. None of the 12 RN competency folders contained sufficient evidence that core and unit/position-specific competencies had been validated. All of the folders had incomplete or missing validation documentation and outdated forms. This was a repeat finding from our previous CAP review.

Competency Validation Methods. The Joint Commission requires facilities to specify the assessment methods used (such as test taking, demonstration, or simulation) to determine an individual's competency in required skills. We found that validation methods were not specified for the skill being assessed and validated.

Recommendations

5. We recommended that managers identify core and unit/position-specific RN competencies and that competencies are assessed and validated according to facility policy.

6. We recommended that managers take appropriate action when staff competency does not meet expectations and document actions taken.

7. We recommended that processes be strengthened to ensure that competency validation documentation is complete and current.

8. We recommended that core and unit/position-specific competency validation documentation specify the methods used to assess and validate competency.

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 and whether the facility's SA and PTSD RRTPs were in compliance with selected Mental Health RRTP requirements.

At the Cooper campus, we inspected the dental and primary care outpatient clinics; the ED; and the intensive care, locked mental health, and medical-surgical units. At the Leestown campus, we inspected the dental, women's health, and primary care outpatient clinics; the CLC; and the SA and PTSD RRTPs. We found that the facility maintained a generally clean and safe environment. However, we identified the following conditions that needed improvement.

Medication Security. Local policy requires that medications no longer being taken by a veteran in the SA RRTP be returned to pharmacy as soon as possible for destruction. We found that staff crushed the medications and mixed them with coffee grounds, which were disposed of in sharps containers.

Additionally, local policy requires that staff in the PTSD RRTP follow the approved protocol for disposing of medications no longer used by veterans. However, the policy does not define a protocol.

Recommendations

9. We recommended that staff in the SA RRTP follow the policy for the destruction of medications.

10. We recommended that a protocol for disposal of medications in the PTSD RRTP be clearly defined and that compliance be monitored.

Management of Workplace Violence

The purpose of this review was to determine whether VHA facilities issued and complied with comprehensive policy regarding violent incidents and provided required training.

We reviewed the facility's policy and training plan. We selected three assaults that occurred at the facility within the past 2 years, discussed them with managers, and reviewed applicable documents. We identified the following areas that needed improvement.

Facility Policy. Local policy requires managers who receive a complaint of violence, threats, or harassment to investigate the complaint and complete an "Incident Documentation Form." We found that managers did not complete the "Incident Documentation Form."

Training Plan. VHA requires that all staff working in the ED receive prevention and management of disruptive behavior

training at orientation and annually.[6] The facility training plan included prevention and management of disruptive behavior training for all employees during orientation but did not include annual refresher training for high-risk employees.

Recommendations

11. We recommended that managers comply with all elements of the facility policy pertaining to management of workplace violence.

12. We recommended that the facility training plan be revised to include annual refresher prevention and management of disruptive behavior training for all high-risk staff.

EN Safety

The purpose of this review was to evaluate whether the facility established safe and effective EN procedures and practices in accordance with applicable requirements.

We reviewed policies and documents related to EN and patients' medical records. We also inspected areas where EN products were stored while conducting the EOC review, and we interviewed key employees. We identified the following area that needed improvement.

EN Documentation. VHA requires that staff document specific EN information in patients' medical records.[7] We reviewed the medical records of 15 EN patients and found that 5 records did not contain all required information. For example, four records did not include physician orders for patient positioning and checking gastric residuals. Facility leaders implemented an order set in May 2011 that included all required elements.

Recommendation

13. We recommended that compliance with the use of the newly implemented EN order set be monitored.

Coordination of Care

The purpose of this review was to evaluate whether the facility managed advance care planning and ADs in accordance with applicable requirements.

We reviewed patients' medical records for evidence of AD notification, AD screening, and documentation of advance care planning discussions. We also reviewed the facility's

[6] VHA Directive 2009-008 (also listed as 2010-008) *Standards for Mental Health Coverage in Emergency Departments and Urgent Care Clinics in VHA Facilities*, February 22, 2010.
[7] VHA Handbook 1109.05, *Specialized Nutritional Support*, May 10, 2007.

policy to determine whether it was consist with VHA policy. We identified the following area that needed improvement.

AD Notification. VHA requires that patients receive written notification at each admission to a VHA inpatient facility stating their right to accept or refuse medical treatment, to designate a Health Care Agent, and to document their treatment preferences in an AD.[8] As part of notification, patients must be informed that VA does not discriminate against patients based on whether or not they have an AD. We reviewed the medical records of 20 patients and found that 16 of the records did not contain evidence of all components of written notification.

Recommendation

14. We recommended that processes be strengthened to ensure that all components of written AD notification are provided to patients and that notification is documented in the medical record.

Review Activity Without Recommendations

Medication Management

The purpose of this review was to determine whether the facility employed safe practices in the preparation, transport, and administration of hazardous medications, specifically chemotherapy, in accordance with applicable requirements.

We observed the compounding and transportation of chemotherapy medications and the administration of those medications in the oncology clinic, and we interviewed employees. We determined that the facility safely prepared, transported, and administered the medications. We made no recommendations.

Comments

The VISN and Facility Directors agreed with the CAP review findings and recommendations and provided acceptable improvement plans. (See Appendixes D and E, pages 14–20 for full text of the Directors' comments.) We will follow up on the planned actions until they are completed.

[8] VHA Handbook 1004.02, *Advance Care Planning and Management of Advance Directives*, July 2, 2009.

Facility Profile[9]		
Type of Organization	Tertiary care medical center	
Complexity Level	1c	
VISN	9	
Community Based Outpatient Clinics	Berea, KY Hazard, KY Morehead, KY Somerset, KY	
Veteran Population in Catchment Area	90,658	
Type and Number of Total Operating Beds: • **Hospital, including Psychosocial RRTP**	138	
• **CLC/Nursing Home Care Unit**	61	
Medical School Affiliation(s)	University of Kentucky Medical Center	
• **Number of Residents**	83	
	FY 2011 (through March 2011)	**Prior FY (2010)**
Resources (in millions):		
• **Total Medical Care Budget**	$219.5	$224.5
• **Medical Care Expenditures**	$113.5	$224.5
Total Medical Care Full-Time Employee Equivalents	1,255.1	1,274.6
Workload:		
• **Number of Station Level Unique Patients**	31,466	35,498
• **Inpatient Days of Care:**		
o **Acute Care**	13,459	28,577
o **CLC/Nursing Home Care Unit**	9,345	19,680
Hospital Discharges	3,582	7,385
Total Average Daily Census (including all bed types)	149.8	147
Cumulative Occupancy Rate (in percent)	75	74
Outpatient Visits	221,969	438,871

[9] All data provided by facility management.

Follow-Up on Previous Recommendations			
Recommendations	**Current Status of Corrective Actions Taken**	**In Compliance Y/N**	**Repeat Recommendation Y/N**
QM			
1. Ensure root cause analysis actions are monitored, measurable, and evaluated for effectiveness.	An internal process was developed to ensure that root cause analysis actions are strong and that outcome measures are quantifiable, which allows managers to evaluate effectiveness.	Y	N
2. Require that data on resuscitation events and outcomes is discussed, analyzed, and compared over time to identify opportunities for improvement.	A critical care nurse specialist is responsible for maintaining the National Registry of Cardiopulmonary Resuscitation database and providing monthly reports to the Critical Care Committee. Oversight of the Critical Care Committee is now assigned to the Clinical Executive Council.	Y	N
3. Ensure that medical records reviews are completed in accordance with VHA policy and that deficiencies are addressed.	Reporting matrices were developed to summarize all ongoing point-of-care and medical record reviews. Point-of-care and medical records reviews have been added to the Medical Record Committee agenda template as monthly recurring report items. Findings, actions, and recommendations are reviewed and/or addressed by the Clinical Executive Council.	Y	N

Recommendations	Current Status of Corrective Actions Taken	In Compliance Y/N	Repeat Recommendation Y/N
4. Require that provider performance improvement data is collected, analyzed, and used to support decisions during the reprivileging process.	Provider performance improvement data is part of the reprivileging process. Service level audits are done every 6 months to assure compliance.	N	Y (see page 4)
Coordination of Care			
5. Ensure discharge instructions, discharge summaries, and physician orders are consistent.	A discharge summary template that imports the pharmacy note medication list was implemented in February 2011.	Y	N
6. Require inter-facility transfer documentation to comply with VHA policy.	The inter-facility transfer note template contains documentation of the availability of consent to transfer.	Y	N
Nursing Competencies			
7. Develop a system to assure that all ED nursing staff competencies are evaluated and documented annually.	Competencies are sent forward and filed with the annual nurse proficiencies.	N	Y (see page 5)
Medication Management			
8. Require that nurses consistently document the effectiveness of all patient medications within the timeframe established by local policy.	Effectiveness of as needed medications is reported quarterly to the Bar Code Medication Administration Committee. Compliance is at 94 percent.	Y	N

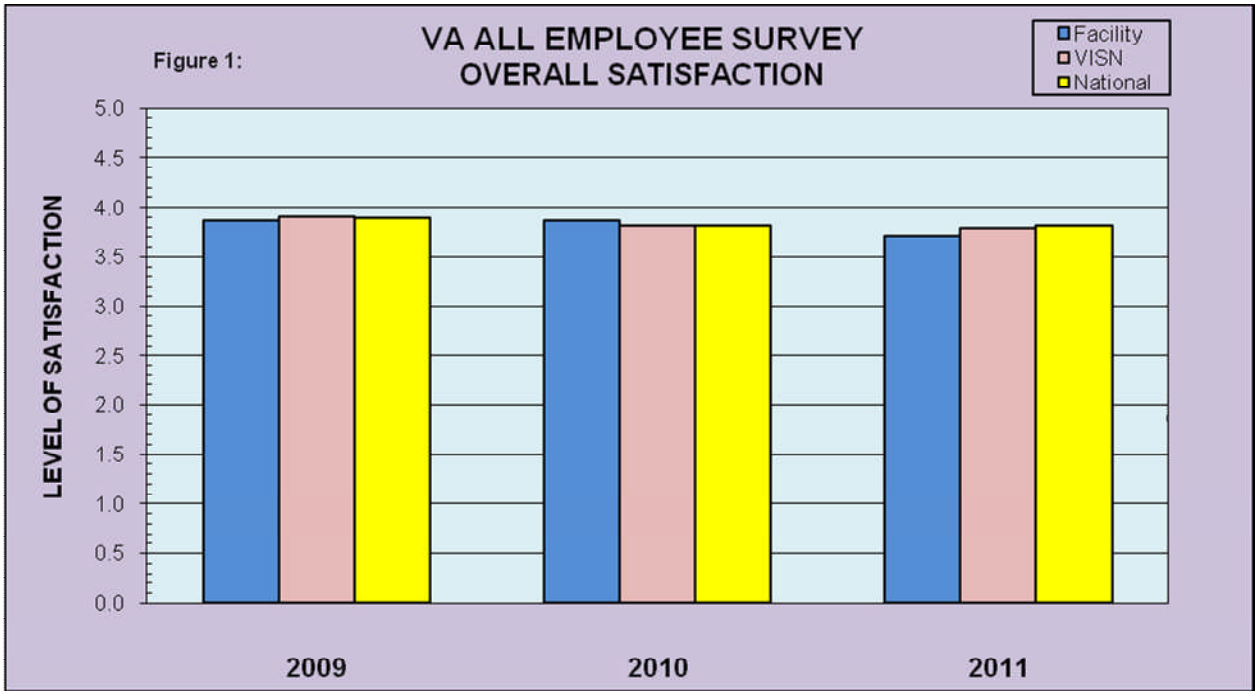
VHA Satisfaction Surveys

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 and targets for quarters 3 and 4 of FY 2010 and quarters 1 and 2 of FY 2011.

Table 1

	FY 2010			FY 2011		
	Inpatient Score Quarters 3–4	Outpatient Score Quarter 3	Outpatient Score Quarter 4	Inpatient Score Quarters 1–2	Outpatient Score Quarter 1	Outpatient Score Quarter 2
Facility	61.9	57.6	58.1	62.3	59.6	62.6
VISN	62.9	54.4	54.7	62.1	57.1	56.0
VHA	64.1	54.8	54.4	63.9	55.9	55.3

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.



Hospital Outcome of Care Measures

Hospital Outcome of Care Measures show what happened after patients with certain conditions[10] received hospital care. The mortality (or death) rates focus on whether patients died within 30 days of their hospitalization. The rates of readmission focus on whether patients were hospitalized again within 30 days. Mortality rates and rates of readmission show whether a hospital is doing its best to prevent complications, teach patients at discharge, and ensure patients make a smooth transition to their home or another setting. The hospital mortality rates and rates of readmission are based on people who are 65 and older. These comparisons are "adjusted" to take into account their age and how sick patients were before they were admitted to the VA facility. Table 2 below shows the facility's Hospital Outcome of Care Measures for FYs 2006–2009.

Table 2

	Mortality			Readmission		
	Heart Attack	Congestive Heart Failure	Pneumonia	Heart Attack	Congestive Heart Failure	Pneumonia
Facility	13.74	11.18	19.72	22.79	27.56	17.33
VHA	13.31	9.73	15.08	20.57	21.71	15.85

[10] Congestive heart failure is a weakening of the heart's pumping power. With heart failure, your body does not get enough oxygen and nutrients to meet its needs. A heart attack (also called acute myocardial infarction) happens 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 in a timely manner, the heart muscle becomes damaged from lack of oxygen. Pneumonia is a serious lung infection that fills your lungs with mucus and causes difficulty breathing, fever, cough, and fatigue.

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: September 7, 2011

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

Subject: **CAP Review of the Lexington VA Medical Center, Lexington, KY**

To: Director, San Diego Office of Healthcare Inspections (54SD)

Director, Management Review Service (VHA 10A4A4 Management Review)

1. I concur with the attached facility draft responses to the recommendations for improvement contained in the Combined Assessment Program Review of the Lexington VA Medical Center, Lexington, KY.

2. If you have additional questions or concerns, please contact Tammy Williams, RN, VISN 9 Continuous Readiness Review Coordinator or Joseph Schoeck, VISN 9 Staff Assistant to the Network Director 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: August 30, 2011

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

Subject: **CAP Review of the Lexington VA Medical Center, Lexington, KY**

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

1. On behalf of the Lexington VA Medical Center, I would like to thank you for the opportunity to review the OIG report. I concur with the findings and recommendations.

2. Included are our responses to the recommendations in the report. Although we have already been actively working on improvements, we appreciate the perspective from the OIG evaluation. We will take this opportunity to strengthen and improve our medical center.

(original signed by:)
DeWayne Hamlin
Director, Lexington VA Medical Center

Comments to Office of Inspector General's Report

The following Director's comments are submitted in response to the recommendations in the Office of Inspector General report:

OIG Recommendations

Recommendation 1. We recommended that PR findings be reported to the MEC quarterly and that PRs are either completed within 120 days or have extensions requested in writing from and approved by the facility's Director.

Concur Target date for completion: Completed/ongoing

The 4th Qtr FY10 and 1st Qtr FY11 PR reports were reviewed at the July 2011 Clinical Executive Board (CEB). Quarterly PR reports will be forward for CEB review by the second Wednesday of the month following the quarterly suspense. A tracking sheet has been implemented by the peer review committee. Elements of the peer review process are being tracked; including the number of days the peer review cases is open. Written extensions will be requested from the Director for all cases not meeting the 120-day.

Recommendation 2. We recommended that processes be strengthened to ensure that pre-sedation risk assessments are consistently performed and documented prior to moderate sedation procedures.

Concur Target date for completion: September 30, 2011

The documentation process within specific services did not facilitate completion of the pre-sedation risk assessment. The Interventional Radiology documentation system has been revised to include an area for the assignment of the ASA. In Cath Lab when the pre-procedure note by cardiologists, which documents the ASA, is not used then the front page of the moderate sedation purple sheet area that includes the ASA assignment will be completed by physician and attached to MAC-lab document for vista imaging. This has been implemented. In Bronchoscopy physicians fill out the moderate sedation purple sheet with ASA. Proposed revision to Moderate Sedation Policy for Non-Anesthesia providers will require all physician documentation, including ASA, to be completed prior to any sedation medications being administered.

Recommendation 3. We recommended that all non-anesthesia providers who perform moderate sedation have documented evidence of ACLS certification or the equivalent in their training records.

Concur Target date for completion: September 30, 2011

The providers without ACLS were cardiologists. The Moderate Sedation policy will be revised to state, "Cardiologists and cardiology fellows have equivalent (actually much

more extensive) training and are exempt from the ACLS requirement." They still must take the "Moderate Sedation National Training Program."

Recommendation 4. We recommended that service chiefs collect and maintain meaningful competency data for all providers and that the MEC review actual performance data prior to making reprivileging decisions.

Concur Target date for completion: November 1, 2011

The medical center policy will be revised to include information to clarify what types of data are meaningful criteria for use in OPPE. The service chiefs and key staff will be educated regarding the types of data to use and service level criteria will be revised for those services found to be deficient and the new criteria approved by the MEC. The actual reprivileging data will be filed in the OPPE folder and the folder presented to Medical Executive Council at the time of reprivileging.

Recommendation 5. We recommended that managers identify core and unit/position-specific RN competencies and that competencies are assessed and validated according to facility policy.

Concur Target date for completion: April 30, 2012

Core and unit/position-specific RN competences have been identified. The proficiency competency will be formatted to match the indentified competencies per unit by October 1, 2011. Assessment and validation will be completed at orientation and in the annual competency fair (January–April). Just in time competency assessment and validation will be done as need arises.

Recommendation 6. We recommended that managers take appropriate action when staff competency does not meet expectations and document actions taken.

Concur Target date for completion: April 30, 2012

With the use of an annual competency fair during the same time each year (Jan thru April), those who are unable to demonstrate competency will receive retraining. If competency is not achieved appropriate action will be under taken. Actions taken to achieve competency will be documented in the staff member's competency folder.

Recommendation 7. We recommended that processes be strengthened to ensure that competency validation documentation is complete and current.

Concur Target date for completion: April 30, 2012

During the annual competency fair completion will be monitored (numerator/denominator) to ensure 100% compliance.

Recommendation 8. We recommended that core and unit/position-specific competency validation documentation specify the methods used to assess and validate competency.

Concur Target date for completion: Completed

Proficiency competency forms have been revised to add core and unit/position-specific method used to assess and validate competency.

Recommendation 9. We recommended that staff in the SA RRTP follow the policy for the destruction of medications.

Concur Target date for completion: September 30, 2011

Green Environmental Management System (GEMS) Pharmaceutical Waste program is being implemented in the Substance Abuse and PTSD Residential Rehabilitation Treatment Program. All excess/discontinued medication with the exception of controlled substances and liquids will be disposed of in the Pharmaceutical Waste containers. Controlled substances and liquid medications will be returned to pharmacy. 100% of staff has been trained on the process. We are awaiting arrival of the Pharmaceutical waste containers. Full implementation will be completed September 23, 2011. Compliance with the process will be monitored daily on Residential Rehabilitation Treatment Program Rounds Checklist. Monitoring will continue until compliance is 95% for 4 months.

Recommendation 10. We recommended that a protocol for disposal of medications in the PTSD RRTP be clearly defined and that compliance be monitored.

Concur Target date for completion: September 30, 2011

Green Environmental Management System (GEMS) Pharmaceutical Waste program is being implemented in the Substance Abuse and PTSD Residential Rehabilitation Treatment Program. All excess/discontinued medication with the exception of controlled substances and liquids will be disposed of in the Pharmaceutical Waste containers. Controlled substances and liquid medications will be returned to pharmacy. 100% of staff has been trained on the process. We are awaiting arrival of the Pharmaceutical waste containers. Full implementation will be completed September 23, 2011. Compliance with the process will be monitored daily on Residential Rehabilitation Treatment Program Rounds Checklist. Monitoring will continue until compliance is 95% for 4 months.

Recommendation 11. We recommended that managers comply with all elements of the facility policy pertaining to management of workplace violence.

Concur Target date for completion: Completed

The facility policy "Workplace Violence Prevention" 07B-10 was revised to match current practice. The "Incident Documentation Form" was removed, and replaced with: "The supervisor/manager will immediately notify the VA Police."

Recommendation 12. We recommended that the facility training plan be revised to include annual refresher prevention and management of disruptive behavior training for all high-risk staff.

Concur Target date for completion: Completed

The revised policy "Workplace Violence Prevention" 07B-10 now includes a training outline for all employees as follows:

(1) Level I training – web based, due annually, and required for all staff.
(2) Level II training – in addition to the web based training, a 4 hour slide show presentation, required for employees dealing with customers but otherwise low risk.
(3) Level III training – all of the above training plus 4 hours of personal safety skills, required for employees in moderate risk areas.
(4) Level IV training – all of the above training plus 4 hours of therapeutic containment, required for employees in high risk areas.

The areas considered to be low risk, moderate risk and high risk are to be determined by the Prevention and Management of Disruptive Behavior (PMDB) coordinator.

Recommendation 13. We recommended that compliance with the use of the newly implemented EN order set be monitored.

Concur Target date for completion: September 1, 2011

Clinical Nutrition will implement a monitor on September 1 to track use of the Inpatient EN Order Set. The medical record of each new tube fed inpatient and Community Living Center (CLC) resident will be reviewed for use of this order set. If it is not used, the responsible dietitian will follow-up with the provider who wrote the order and provide education or assistance as needed. Monitoring of each area will continue until areas are at 95% compliance for 4 months.

Recommendation 14. We recommended that processes be strengthened to ensure that all components of written AD notification are provided to patients and that notification is documented in the medical record.

Concur Target date of completion: Completed/ongoing

Staff were required to review the VHA, Lexington Facility and Health Administration Service Directive/Memorandums on Advance Health Care Planning. Staff reviewed the

"Admission Advanced Directive Progress Note" template and were required to sign their understanding of the required fields in the template. The template includes documentation of the patient receiving all AD notification materials. Weekly audit to ensure compliance with AD screening at the time of admission has been implemented. Exceptions will be reported to staff on a weekly basis. Report will be shared with: Chief, HAS, Assistant Chief, HAS and Chief, AC&P, Supervisor, Patient Support Unit. Once 95% compliance has been achieved for 3 consecutive months, auditing will be provided on a monthly basis.

OIG Contact and Staff Acknowledgments

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