Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 10-01438-231

Combined Assessment Program Review of the VA Greater Los Angeles Healthcare System Los Angeles, California

August 24, 2010

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.

To Report Suspected Wrongdoing in VA Programs and Operations
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E-Mail: vaoighotline@va.gov
(Hotline Information: http://www.va.gov/oig/contacts/hotline.asp)

Glossary

ACLS	Advanced Cardiac Life Support
ACR	American College of Radiology
BLS	Basic Life Support
C&P	credentialing and privileging
CAP	Combined Assessment Program
CBOC	community based outpatient clinic
CLC	community living center
COC	coordination of care
CRD	chronic renal disease
EOC	environment of care
ED	emergency department
ESA	erythropoiesis stimulating agent
facility	VA Greater Los Angeles Healthcare System
FDA	U.S. Food and Drug Administration
FPPE	Focused Professional Practice Evaluation
FY	fiscal year
FTE	full-time employee equivalents
g/dL	grams per deciliter
JC	Joint Commission
LAACC	Los Angeles Ambulatory Care Center
MRI	magnetic resonance imaging
MEC	Medical Executive Committee
MH	mental health
OIC	Organizational Improvement Council
OIG	Office of Inspector General
OSHA	Occupational Safety and Health Administration
PI	performance improvement
QM	quality management
RME	reusable medical equipment
SOP	standard operating procedure
SPD	Supply, Processing, and Distribution
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network
WLA	West Los Angeles

Table of Contents

Executive Summary: Combined Assessment Program Review of the VA Greater Los Angeles Healthcare System, Los Angeles, California

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 June 21, 2010.

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

- Reusable Medical Equipment

The facility's reported accomplishments included an award-winning patient flow program, a model domiciliary program, and a patient-centered care program that resulted in improved patient satisfaction.

Recommendations: We made recommendations in the following seven activities:

Quality Management: Report peer review findings to the Medical Executive Committee quarterly, implement an effective tracking system to ensure life support training or certification is current for all designated clinical staff, revise the local policy to specify actions to be taken when training or certification is not current, and review and analyze all resuscitation episodes.

Environment of Care: Train designated staff on bloodborne pathogens and on mental health environmental hazards recognition and ensure staff identified as at risk for exposure to airborne infections receive annual respirator fit testing.

Magnetic Resonance Imaging Safety: Document review of patient screening questionnaires.

Physician Credentialing and Privileging: Comply with Veterans Health Administration requirements for Focused Professional Practice Evaluation and reprivileging.

Medication Management: Take and document appropriate actions when chronic renal disease patients' hemoglobin levels exceed 13 grams per deciliter.

Suicide Prevention Safety Plans: Develop timely safety plans for all patients at high risk for suicide.

Coordination of Care: Consistently complete patient discharge documentation, ensure clinicians document informed consent in all patient transfers, and integrate patient transfers into the quality management program.

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.

(original signed by:)

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

Objectives and Scope

Objectives

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

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:

- COC
- EOC
- Medication Management
- MRI Safety
- Physician C&P
- QM
- RME
- Suicide Prevention Safety Plans

The review covered facility operations for FY 2009 and FY 2010 through April 30, 2010, and was done in accordance with OIG SOPs for CAP reviews. We also followed up on selected recommendations from our prior

CAP review of the facility (*Combined Assessment Program Review of the VA Greater Los Angeles Healthcare System, Los Angeles, California*, Report No. 07-02946-55, January 9, 2008). We identified a repeat finding from our prior review in the area of peer review reporting.

During this review, we also presented crime awareness briefings for 496 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 Accomplishments

Patient Flow Program

In 2008, the facility's Hospital Efficiency Committee recommended patient process improvements to enhance inpatient bed utilization, ED flow, and patient satisfaction. Since implementing actions, the facility has made significant improvements, such as facilitating the discharge process, creating an automated bed cleaning process, and reducing ED diversion time. As a result, in 2009, the program placed third in the VHA Systems Redesign Champions Award.

Domiciliary Program

In 2008, the facility developed a domiciliary program model based on specific evidence-based treatment modalities. The facility expanded the number and mix of the domiciliary interdisciplinary team to ensure that MH, addiction, vocational readiness, and positive wellness skills were developed. In addition, specific programs for women, Operation Enduring Freedom and Operation Iraqi Freedom veterans, and safe medication management were established. Other VA domiciliaries are in the process of implementing a similar model.

Patient-Centered Care Program

In 2008, the facility initiated a program with a private organization to establish patient-centered care initiatives. Patients were requested to provide feedback, and the facility addressed issues such as better human interactions, architectural design/wayfinding, and patient education. Concierge desks on each floor, improved maps, increased patient education materials, and enhanced staff education

have been instituted. These improvements have resulted in higher patient satisfaction scores for the facility.

Results

Review Activities With Recommendations

QM

The purpose of this review was to evaluate whether the facility's QM program provided comprehensive oversight of the quality of care and whether senior managers actively supported the program's activities. We interviewed the facility's Director, the Chief of Staff, the Chief of QM, QM personnel, and several service chiefs. We evaluated plans, policies, and other relevant documents.

The QM program was comprehensive in providing oversight of the facility's quality of care. It was also evident that senior managers supported the program through participation in PI initiatives and provision of resources. However, we identified three areas that needed improvement.

Peer Review. VHA[1] and local policy require quarterly reporting of peer review findings to the MEC. During our prior CAP review, we identified that peer review findings were not consistently presented to the MEC, as required. During this review, we noted that the peer review process was comprehensive and generally in compliance with VHA requirements. However, peer review reports were only presented to the MEC in 2 out of the past 4 quarters. This is a repeat finding from our previous CAP review.

Life Support Training. VHA policy[2] requires that all clinically active staff have cardiopulmonary resuscitation education and that a system is in place to monitor compliance with ACLS and BLS training or certification. In addition, VHA policy requires managers to delineate actions to be taken for noncompliance. We found a decentralized monitoring system with inadequate tracking of certification requirements. For BLS, program managers identified 2,109 employees who were required to have current certification; however, 544 (26 percent) did not have current certification. For ACLS, program managers identified 231 employees who were required to have current certification; however, 13 (6 percent) did not have current certification. We were told that ACLS status for licensed independent practitioners

[1] VHA Directive 2008-004, *Peer Review for Quality Management*, January 28, 2008.
[2] VHA Directive 2008-008, *Cardiopulmonary Resuscitation (CPR) and Advanced Cardiac Life Support (ACLS) Training for Staff*, February 6, 2008.

(such as physicians and nurse practitioners) was not monitored. Also, the local policy did not include specific actions to be taken for employees who did not meet the BLS/ACLS certification requirement, and we found no evidence of any actions.

Resuscitation and Its Outcomes. VHA[3] and local policy require each episode of care where resuscitation was attempted to be reviewed on both an individual basis and in aggregate to identify improvement opportunities. We found that for 43 (36 percent) of the 119 cardiac arrests that occurred during the past 12 months, critique forms were not available for analysis. Therefore, the facility was unable to accurately review and analyze resuscitation and its outcomes to identify opportunities for improvement.

Recommendations

1. We recommended that peer review reports be presented quarterly to the MEC, as required.

2. We recommended that the facility implement an effective tracking system to ensure that designated clinical staff maintain current BLS and ACLS training or certification and that the local policy is revised to specify appropriate actions to be taken when BLS and ACLS training or certification is not current.

3. We recommended that all resuscitation episodes be reviewed and analyzed, as required.

EOC

The purpose of this review was to determine whether VHA facilities maintained a safe and clean health care environment. VHA facilities are required to establish a comprehensive EOC program that fully meets VHA, National Center for Patient Safety, OSHA, National Fire Protection Association, and JC standards.

At the WLA campus, we inspected selected inpatient (medical, surgical, intensive care, MH, CLC) units, the Clinical Procedure Center, the Post-Anesthesia Care Unit, the domiciliary, specialty clinics (urology and women's health), the ED, and the dialysis unit. At the Sepulveda campus, we inspected a primary care and a specialty clinic and the CLC. At the LAACC, we inspected several clinical areas. Overall, we found the areas inspected to be

[3] VHA Directive 2008-063, *Oversight and Monitoring of Cardiopulmonary Resuscitative Events and Facility Cardiopulmonary Resuscitation Committees,* October 17, 2008.

clean and well maintained. However, we identified the following conditions that needed improvement.

Training. Infection control guidelines require that employees at risk for exposure to bloodborne pathogens receive annual training on the OSHA Bloodborne Pathogens Rule. We reviewed training records for 69 employees and found that 16 (23 percent) did not have the required training. Also, VHA requires[4] that staff who work on locked inpatient psychiatric units and members of the Multidisciplinary Safety Inspection Team receive initial and annual training on the environmental hazards that represent a threat to suicidal patients. We reviewed training records for 12 clinical staff and found that 11 (92 percent) did not have the required training.

Respirator Fit Testing. OSHA requires annual N95 respirator fit testing for staff who are at risk for exposure to certain airborne infections. We reviewed annual fit testing documentation for 20 employees designated by infection control practitioners as at high risk for exposure and found that 9 (45 percent) did not receive the required fit testing.

Recommendations

4. We recommended that designated employees receive the required bloodborne pathogens and mental health environmental hazards training.

5. We recommended that N95 respirator fit testing be provided annually to staff identified as at risk for exposure to airborne infections.

MRI Safety

The purpose of this review was to evaluate whether the facility maintained a safe environment and safe practices in the MRI area. Safe MRI procedures minimize risk to patients, visitors, and staff and are essential to quality patient care. VA's MRI safety policy is detailed in an online resource guide that establishes requirements for safe MRI practices.[5]

We inspected the MRI area, examined patient and employee records, reviewed relevant policies, and interviewed key personnel. We determined that the facility had adequate safety policies and had appropriately conducted a risk assessment of the environment, as required by The JC. We found appropriate signage. We noted that patients were

[4] Deputy Under Secretary for Health for Operations and Management, "Mental Health Environment of Care Checklist," memorandum, August 27, 2007.
[5] VA Radiology, "Online Guide," <http://vaww1.va.gov/Radiology/page.cfm?pg=167>, updated December 20, 2007, Secs. 4.1–4.3.

directly observed during an MRI exam. Two-way communication was available between the patient and the MRI technologist, and patients had access to a push-button call system. Additionally, MRI and non-MRI personnel who have access to the MRI area had completed required safety training. However, we identified the following area that needed improvement.

Safety Screening. VA[6] and the ACR require screening of patients undergoing MRI using a standard screening questionnaire. MRI technologists are required to review and sign the questionnaires before a patient is scanned. We reviewed the medical records of 20 patients who underwent an MRI at the Sepulveda and WLA campuses. Of the 20 records reviewed, 10 (50 percent) had no documented evidence of the required screening.

Recommendation

6. We recommended that MRI technologists document their review of patient screening questionnaires.

Physician C&P

The purpose of this review was to determine whether the facility maintained consistent processes for physician C&P. For a sample of physicians, we reviewed selected VHA required elements in C&P files and provider profiles.[7] We also reviewed meeting minutes during which the physicians' privileges were discussed and recommendations were made.

We reviewed 12 physicians' C&P files and profiles and found that licenses were current and that primary source verification had been obtained. The plan for ongoing monitoring of professional practice was in place. However, we identified two areas that needed improvement.

FPPE. VHA policy requires that the results of FPPE be reported to the MEC for consideration in making recommendations on privileges for newly hired physicians. We found that FPPEs for three physicians whose files we reviewed were not reported to the MEC.

Minutes Documenting C&P Discussions. VHA requires certain elements (such as requested privileges, service chief's recommendation, and other supporting information) to be presented to the MEC for review and recommendation. Professional Standards Board and MEC minutes documented specific discussions supporting the granting of

[6] VA Radiology, "Online Guide."
[7] VHA Handbook 1100.19, *Credentialing and Privileging*, November 14, 2008.

privileges for new providers. However, the minutes that contained the discussion of providers undergoing the reprivileging process lacked individualized documentation of credentialing, health status, and individual competence to support the renewal of privileges.

Recommendation

7. We recommended that physician C&P processes be in compliance with VHA requirements for FPPE and reprivileging.

Medication Management

The purpose of this review was to evaluate whether VHA facilities had developed effective and safe medication management practices. We reviewed selected medication management processes for outpatients and CLC residents.

VHA requires several items to be documented for each influenza vaccine given to CLC residents, including the route, site, and date of administration.[8] We reviewed the medical records of five patients who received the influenza vaccine. Clinicians documented all required elements except the name of the manufacturer. While we were onsite, program managers revised the influenza documentation template to include the name of the manufacturer and the expiration date of the vaccine. Therefore, we did not make a recommendation related to this finding. However, we identified the following area that needed improvement.

Management of ESAs. In November 2007, the FDA issued a safety alert stating that for CRD patients, ESAs[9] should be used to maintain hemoglobin levels between 10 and 12g/dL. Also, the local policy requires clinicians to withhold ESAs if the hemoglobin level is greater than 13g/dL. We reviewed the medical records of 10 outpatients with CRD who had hemoglobin levels greater than 12g/dL. We determined that patients with hemoglobin levels between 12 and 13g/dL were appropriately managed; however, clinicians did not withhold the ESA doses for three (30 percent) patients who had hemoglobin levels greater than 13g/dL. While we were onsite, pharmacy managers instituted a new ESA ordering procedure requiring clinicians to contact nephrology physicians if the hemoglobin level is greater than 12g/dL. In addition, the ESA administration policy in the dialysis unit is under revision to delineate actions to be taken if the

[8] VHA Directive 2009-058, *Seasonal Influenza Vaccine Policy for2009–2010*, November 12, 2009.
[9] Drugs that stimulate the bone marrow to make red blood cells; used to treat anemia.

hemoglobin level is outside the maintenance levels of 10 and 12g/dL.

Recommendation

8. We recommended that clinicians take and document appropriate actions when CRD patients' hemoglobin levels exceed 13g/dL.

Suicide Prevention Safety Plans

The purpose of this review was to determine whether clinicians had developed safety plans that provided strategies to mitigate or avert suicidal crises for patients assessed to be at high risk for suicide. Safety plans should have patient and/or family input, be behavior oriented, and identify warning signs preceding crisis and internal coping strategies. They should also identify when patients should seek non-professional support, such as from family and friends, and when patients need to seek professional help. Safety plans must also include information about how patients can access professional help 24 hours a day, 7 days a week.[10]

A previous OIG review of suicide prevention programs in VHA facilities[11] found a 74 percent compliance rate with safety plan development. The safety plan issues identified in that review were that plans were not comprehensive (did not contain the above elements), were not developed timely, or were not developed at all. At the request of VHA, the OIG agreed to follow up on the prior findings.

Overall, we found a comprehensive program. We noted strong program oversight by the suicide prevention coordinators. However, we identified the following area that needed improvement.

Safety Plans. We reviewed the medical records of 10 patients assessed to be at high risk for suicide. The safety plans for three (30 percent) patients were either not developed timely (20 percent) or not developed at all (10 percent). Prior to our site visit, program managers had identified improvement opportunities in this area and had initiated ongoing training to improve performance. Although the facility's current performance rate exceeds the national compliance rate of 74 percent, program managers are optimistic that a goal of 100 percent compliance is

[10] Deputy Under Secretary for Health for Operations and Management, "Patients at High-Risk for Suicide," memorandum, April 24, 2008.
[11] *Healthcare Inspection – Evaluation of Suicide Prevention Program Implementation in Veterans Health Administration Facilities January–June, 2009;* Report No. 09-00326-223; September 22, 2009.

achievable. Program managers agreed to continue to monitor clinician's compliance with safety plan development.

Recommendation

9. We recommended that clinicians consistently develop timely safety plans for patients identified as being at high risk for suicide.

COC

The purpose of this review was to evaluate whether discharges and inter-facility transfers were coordinated appropriately over the continuum of care and met VHA and JC requirements. Coordinated discharges and transfers are essential to an integrated, ongoing care process and optimal patient outcomes. We identified improvement opportunities in the following areas.

Physician Discharge Documentation. VHA policy[12] and JC standards require that providers include information regarding medications, diet, activity level, and follow-up appointments in written patient discharge instructions. In addition, the local policy requires physicians to write discharge instructions using a locally developed note template (Patient Discharge Information and Education Note).

We reviewed the medical records of 10 discharged patients. We noted timely and complete nursing, nutrition, and pharmacy discharge documentation. However, for two (20 percent) discharged patients, physicians did not use the template, and there were no discharge instructions. The missing documentation involved discharges from the psychiatry units. To determine the extent of missing discharge documentation in psychiatry, we reviewed 10 additional medical records of recently discharged psychiatry patients. We found that three (30 percent) records did not have discharge instruction notes.

Inter-Facility Transfer Documentation and PI Process. VHA policy[13] requires specific information (such as the reason for transfer, advance directive acknowledgment, and informed consent to transfer) to be recorded in the transfer documentation. The facility had developed a transfer note template to record all required information prior to transfer.

We reviewed documentation for 10 patients who transferred to another facility. For six (60 percent) of the transfers,

[12] VHA Handbook 1907.01, *Health Information Management and Heath Records,* August 25, 2006.
[13] VHA Directive 2007-015, *Inter-Facility Transfer Policy,* May 7, 2007.

clinicians did not document the informed consent to transfer. Program managers informed us that all patients had electronic informed consents. However, this information was not reflected in the transfer notes.

VHA policy also requires inter-facility transfers to be monitored and evaluated as part of the QM program. We did not find evidence that transfers were integrated in the facility's QM program. While we were onsite, program managers identified the OIC as the appropriate committee to review, assess, and implement PI activities related to patient transfers. Also, the local policy describes PI activities, such as data collection and analysis of patient transfers. However, we did not find a formal PI process. Program managers agreed to revise the local policy to reflect the OIC's involvement.

Recommendations

10. We recommended that psychiatry physicians consistently complete patient discharge documentation, as required.

11. We recommended that clinicians document informed consent in all patient transfer notes and that program managers integrate inter-facility transfers in the facility's QM program.

Review Activity Without Recommendations

RME

The purpose of this review was to evaluate whether the facility had processes in place to ensure effective reprocessing of RME. Improper reprocessing of RME may transmit pathogens to patients and affect the functionality of the equipment. VHA facilities are responsible for minimizing patient risk and maintaining an environment that is safe. The facility's SPD and satellite reprocessing areas are required to meet VHA, Association for the Advancement of Medical Instrumentation, OSHA, and JC standards.

We inspected SPD, the hemodialysis unit, a satellite reprocessing area (5E), and a flash sterilization area in the operating room. We determined that the facility had appropriate policies and procedures and consistently monitored compliance with established guidelines. Also, the facility had a process in place to track RME should a sterilization failure occur.

For 12 pieces of RME, we reviewed the SOPs for reprocessing. In general, we found that SOPs were current

and consistent with the manufacturers' instructions. Also, employees were able to demonstrate the cleaning procedures in the SOPs and verbalize the steps. We reviewed the competency folders and training records of the employees who demonstrated or verbalized the cleaning procedures and found that annual competencies and training were current and consistently documented. In addition, we noted that the facility had significantly improved its flash sterilization practices.

VA policy[14] requires formal reporting of certain RME program elements (such as infection control, SOP compliance, staff training, and competency) to an executive-level committee. The facility had implemented an informal reporting process for RME, and we found evidence of data collection and VISN-level reporting. While we were onsite, program managers agreed to formalize the reporting process to ensure compliance. Therefore, 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 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.

[14] VA Handbook 7176; *Supply, Processing and Distribution (SPD) Operational Requirements*; August 16, 2002.

Facility Profile[15]		
Type of Organization	Tertiary care medical center	
Complexity Level	1a	
VISN	22	
CBOCs	Bakersfield East Los Angeles Gardena Lancaster Oxnard Pasadena San Luis Obispo Santa Barbara Santa Maria Los Angeles Sepulveda	
Veteran Population in Catchment Area	493,207	
Type and Number of Operating Beds: • **Acute care**	242	
• **CLC**	203	
• **Other**	N/A	
Medical School Affiliation(s)	University of California, Los Angeles, David Geffen School of Medicine University of Southern California Keck School of Medicine	
• **Number of Residents**	345	
	Current FY	**FY 2009**
Resources (in millions):		
• **Budget**		$608.4
• **Medical Care Expenditures**		$453
FTE		4,406
Workload:		
• **Number of Unique Patients**		80,343
• **Inpatient Days of Care:**		
o **Acute Care**		77,226
o **CLC**		45,852
Hospital Discharges		8,039
Cumulative Average Daily Census (including CLC patients)		411
Cumulative Occupancy Rate		92%
Outpatient Visits		1,168,249

[15] All data provided by facility management.

VHA Satisfaction Surveys

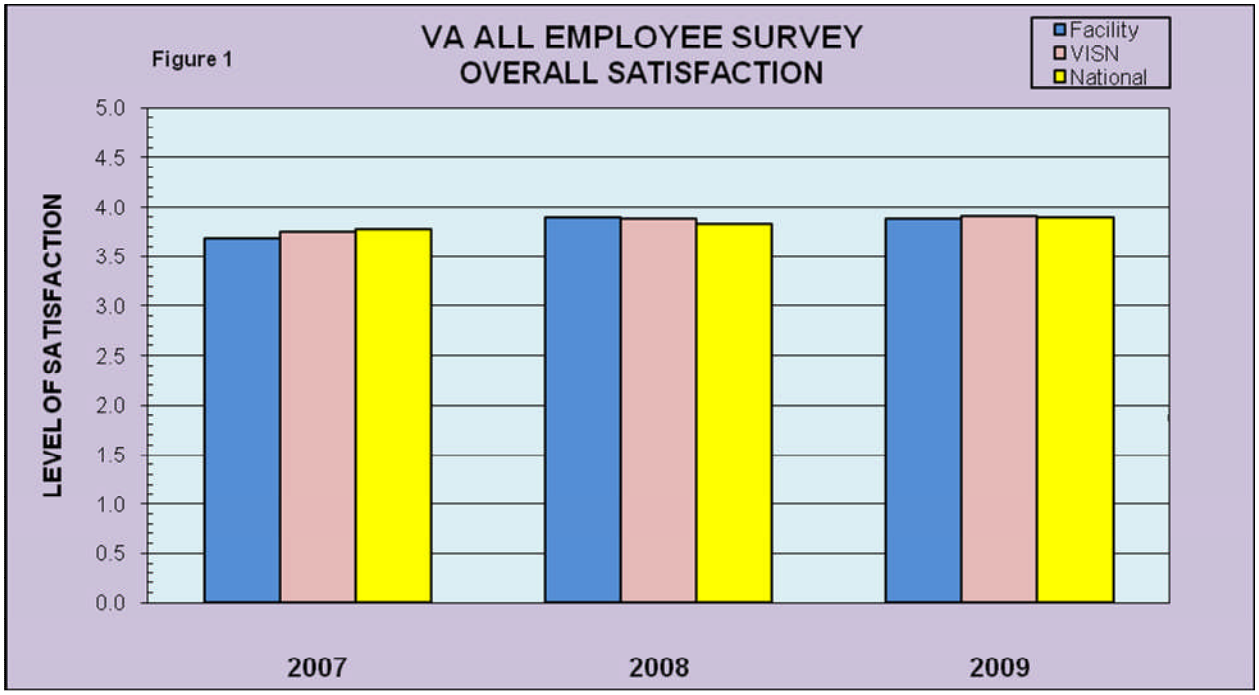
VHA has identified patient and employee satisfaction scores as significant indicators of facility performance. Patients are surveyed monthly. VHA is currently in the process of transitioning to the Consumer Assessment of Healthcare Providers and Systems survey. As a result, data for FY 2009 have been summarized for the entire year. Table 1 below shows the facility's and VISN's calibrated overall inpatient and outpatient satisfaction scores for FY 2009 and overall outpatient satisfaction score and target for the 1st quarter of FY 2010.

Table 1

	FY 2009		FY 2010
	Inpatient Score	Outpatient Score	Outpatient Score 1st Quarter
Facility	63.28	45.51	51.6 (target 56)
VISN	64.96	50.72	53.4 (target 56)

Employees are surveyed annually. Figure 1 below shows the facility's overall employee scores for 2007, 2008, and 2009. Since no target scores have been designated for employee satisfaction, VISN and national scores are included for comparison.

Figure 1



VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: August 6, 2010

From: VA Desert Pacific Healthcare Network (10N/22)

Subject: CAP Review of the VA Greater Los Angeles Healthcare System, Los Angeles, CA (Conducted the week of June 21, 2010)

To: Director, Los Angeles Healthcare Inspections Division (54LA)
Director, Management Review Service (VHA CO 10B5 Staff)

1. VA Desert Pacific Healthcare Network (VISN 22) submits the Draft Report and concurs with the recommendations in the facility response.

2. Please contact Kathryn Bucher, Quality Management Officer, VA Desert Pacific Healthcare Network, at (562) 826-5963, should you need further information.

(*original signed by Barbara Fallen for:)*
Ronald B. Norby,
Network Director

Facility Director Comments

Department of Veterans Affairs **Memorandum**

Date: August 4, 2010

From: Director, VA Greater Los Angeles Healthcare System (691/00)

Subject: CAP Review of the VA Greater Los Angeles Healthcare System, Los Angeles, CA

To: VISN 22 Director

1. Enclosed are the responses to the recommendations in the draft report: Combined Assessment Program Review, Greater Los Angeles Healthcare System, Los Angeles, CA.

2. If you have any questions or would like to discuss the report, please contact me at (310) 268-3132.

(original signed by:)
Donna M. Beiter, R.N., M.S.N.

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:

Recommendation 1. We recommended that peer review reports be presented quarterly to the MEC, as required.

Concur

Target date for completion: August 31, 2010

Action/implementation plan. The MEC schedule has been adjusted to reflect quarterly peer review reports which for the remainder of 2010 are as follows: August 13, 2010 and November 26, 2010. Risk Management will prepare the peer report two weeks prior to the presentation date for inclusion in the MEC agenda and subsequent minutes.

Recommendation 2. We recommended that the facility implement an effective tracking system to ensure that designated clinical staff maintain current BLS and ACLS training or certification and that the local policy is revised to specify appropriate actions to be taken when BLS and ACLS training or certification is not current.

Concur

Target date for completion: October 30, 2010

Action/implementation plan. Nursing Service will develop a data base for tracking all BLS and ACLS training or certification which will be approved by the Medical Executive Committee for use by all GLA eligible clinical staff. The CPR Training policy is being revised to specify appropriate action when BLS and ACLS training is not current. The revised policy will be presented to the Medical Executive Committee upon completion for approval.

Recommendation 3. We recommended that all resuscitation episodes be reviewed and analyzed, as required.

Concur

Target date for completion: October 30, 2010

Facility's action/implementation plan. The resuscitation process is under review with the goal of 1) assuring that all episodes are captured and 2) data analysis to review trends and opportunities for improvement. The revised process will be presented to the Medical Executive Committee for approval.

Recommendation 4. We recommend that designated employees receive the required bloodborne pathogens and mental health environmental hazards training.

Concur

Target date for completion: October 30, 2010

Facility's action/implementation plan. The Environmental Management Service will develop a plan to ensure that all staff that are required to have bloodborne pathogen training will complete the training at the 100% level by the target date. Mental Health has initiated training for all eligible clinical staff on mental health environmental hazard training and will achieve 100% compliance by target date. Results will be reported monthly to the Organizational Improvement Council.

Recommendation 5. We recommended that N95 respirator fit testing be provided annually to staff identified as at risk for exposure to airborne infections.

Concur

Target date for completion: October 30, 2010

Facility's action/implementation plan. Industrial Hygiene will develop and implement plan to complete annual N-95 respirator fit testing for 100% staff identified at risk for exposure to airborne infections. The completion will be presented to the Environment of Care Committee and be reflected in the minutes.

Recommendation 6. We recommended that MRI technologists document their review of patient screening questionnaires.

Concur

Target date for completion: September 30, 2010

Facility's action/implementation plan. The MRI section has developed a plan to document their review of patient screening questionnaires and has begun implementation. The results will be reported to the GLA Organizational Improvement Council.

Recommendation 7. We recommended that physician C&P processes be in compliance with VHA requirements for FPPE and reprivileging.

Concur

Target date for completion: October 30, 2010

Facility's action/implementation plan. A plan to develop a template for including required elements in the Professional Standards Board minutes for MEC review and recommendation has been initiated through the Chief of Staff office. Training assigned

staff to complete the template for MEC review will occur and the process will be initiated and incorporated into the MEC minutes by the target date.

Recommendation 8. We recommended that clinicians take and document appropriate actions when CRD patients' hemoglobin levels exceed 13g/dL.

Concur

Target date for completion: September 30, 2010.

Facility's action/implementation plan. Pharmacy and Renal Service developed a protocol that puts a hold on ESO if Hbg is greater than 13. It further provides that attendings are notified if the Hbg exceeds 12 and the determination can be made for either reducing the dose or holding the medication. The Pharmacy & Therapeutics meeting in August will review the protocol. The Chief of Dialysis chairs a committee that reviews Hbg values along with EPO dosing every two weeks. The data from this committee will be submitted to P & T for review for four months.

Recommendation 9. We recommended that clinicians consistently develop timely safety plans for patients identified as being at high risk for suicide.

Concur

Target date for completion: October 30, 2010

Facility's action/implementation plan. There is a GLA organizational SOP dated 10/09 that specifies the requirements for the suicide risk assessment and safety plans for those patients identified as high risk for suicide through the mechanism of flagging by the Suicide Prevention Coordinator. Monitoring will be done by SPC to assess compliance rate for completion of safety plans within fourteen days of a reported event and results will be reported to the Organizational Improvement Council.

Recommendation 10. We recommended that psychiatry physicians consistently complete patient discharge documentation, as required.

Concur

Target date for completion: September 30, 2010

Facility's action/implementation plan. After educating providers about the need to complete the discharge template, the compliance with discharge template completion is being monitored. Discharge template completion data will be reported to the Organizational Improvement Council.

Recommendation 11. We recommended that clinicians document informed consent in all patient transfer notes and that program managers integrate inter-facility transfers in the facility's QM program.

Concur

Target date of completion: September 30, 2010

Facility's action/implementation plan. The UM section developed a plan for ensuring that informed consent was a part of each transfer note and one of the Transfer Office staff is responsible for monitoring compliance. The compliance data will be reported to the Inpatient Operational Council on a monthly basis and the Organizational Improvement Council on a quarterly basis.

OIG Contact and Staff Acknowledgments

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