Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 11-03654-66

Combined Assessment Program Review of the Memphis VA Medical Center Memphis, Tennessee

January 19, 2012

Washington, DC 20420

Why We Did This Review

Combined Assessment Program (CAP) reviews are part of the Office of Inspector General's (OIG's) efforts to ensure that high quality health care is provided to our Nation's veterans. CAP reviews combine the knowledge and skills of the OIG's Offices of Healthcare Inspections and Investigations to provide collaborative assessments of VA medical facilities on a cyclical basis. The purposes of CAP reviews are to:

- Evaluate how well VA facilities are accomplishing their missions of providing veterans convenient access to high quality medical services.
- Provide crime awareness briefings to increase employee understanding of the potential for program fraud and the requirement to refer suspected criminal activity to the OIG.

In addition to this typical coverage, CAP reviews may examine issues or allegations referred by VA employees, patients, Members of Congress, or others.

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Glossary

CAP	Combined Assessment Program
CRC	colorectal cancer
ED	emergency department
EOC	environment of care
facility	Memphis VA Medical Center
FPPE	Focused Professional Practice Evaluation
FY	fiscal year
HF	heart failure
MEC	Medical Executive Committee
MH	mental health
MRI	magnetic resonance imaging
MSDS	Material Safety Data Sheet
OIG	Office of Inspector General
PRRC	Psychosocial Rehabilitation and Recovery Center
QM	quality management
RRTP	residential rehabilitation treatment program
TBI	traumatic brain injury
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

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Executive Summary: Combined Assessment Program Review of the Memphis VA Medical Center, Memphis, TN

Review Purpose: The purpose was to evaluate selected activities, focusing on patient care administration and quality management, and to provide crime awareness training. We conducted the review the week of October 3, 2011.

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

- Coordination of Care
- Medication Management

The facility's reported accomplishments were the Polytrauma Skills Training Program for veterans with traumatic brain injury and an award to install environmental control units at spinal cord injury patients' bedsides.

Recommendations: We made recommendations in the following six activities:

Colorectal Cancer Screening: Notify patients of positive screening results. Ensure that clinicians develop follow-up plans if indicated and that patients with positive screening results receive diagnostic tests. Notify patients who had diagnostic tests and biopsies of the results within the required timeframe, and document notification.

Moderate Sedation: Ensure that all required staff receive training. Require pre-sedation assessment documentation to include all required elements. Ensure that informed consents are completed appropriately and that changes are discussed with and approved by patients. Require team members to document their participation in the pre-procedure timeout. Ensure a reliable system is in place to monitor the use of reversal agents.

Environment of Care: Conduct an inspection of the emergency department, and take actions to correct cleanliness deficiencies. Ensure Material Safety Data Sheet inventory lists and hazardous material information sheets are current. Require that all laser safety glasses are labeled, that all laser users complete training, and that compliance is monitored. Ensure that documentation of Mental Health Residential Rehabilitation Treatment Program inspections contains all required elements and that corrective actions are initiated.

Quality Management: Initiate Focused Professional Practice Evaluations prior to the delivery of care, and report results to the Medical Executive Committee.

Psychosocial Rehabilitation and Recovery Centers: Ensure that all required clinical services are offered or that an action plan is in place.

Polytrauma: Ensure required staffing levels are maintained.

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.

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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
- CRC Screening
- EOC
- Medication Management
- Moderate Sedation
- Polytrauma
- PRRCs
- QM

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

The review covered facility operations for FY 2010, FY 2011, and FY 2012 through October 3, 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 Memphis VA Medical Center, Memphis, Tennessee,* Report No. 10-00046-32, November 22, 2010. (See Appendix B for further details.)

During this review, we also presented crime awareness briefings for 375 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 507 responded. Survey results were shared with the facility Director.

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

Polytrauma Skills Training

The Polytrauma Team offers a curriculum for returning veterans with TBI and their families. The program is available 2 days a week, and some courses are offered during evening hours to promote accessibility for veterans with employment or childcare issues. The program offers evidenced-based treatment groups aimed at improving the physical, social, emotional, and cognitive adaptation of these veterans. Courses include anger management; skills training to improve attention, memory, and communication; and yoga. The program also includes a course to help veterans with mild TBI prepare for college coursework ("SMART START"). This program was recognized as a strength in a recent survey by the Commission on Accreditation of Rehabilitation Facilities and has been adopted as a model of practice by other facilities within VISN 9.

Environmental Control Units

Biomedical Engineering staff entered the VA Innovation Competition after identifying a need for better environmental control units for spinal cord injury patients. The facility was awarded a grant for $728,150. This money will allow the facility to install an environmental control unit and television at the bedside of each spinal cord injury patient. Patients will be able to control the television, the bed, and the lights; dial the phone and receive phone calls; and call the nurse. They will also have the ability to access the internet, play computer games, and read e-books. The units can be controlled by voice activation, eye gaze, switch control, "sip-n-puff," or touch screen, making them available to patients with a wide range of capabilities.

Results

Review Activities With Recommendations

CRC Screening

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

We reviewed the medical records of 20 patients who had positive CRC screening tests, and we interviewed key employees involved in CRC management. The areas marked as noncompliant in the table below needed improvement. Details regarding the findings follow the table.

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

Positive CRC Screening Test Result Notification. VHA requires that patients receive notification of positive CRC screening test results within 14 days of the laboratory receipt date for fecal occult blood tests and that clinicians document notification.[1] Three patients' records did not contain documented evidence of timely 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.[2] Four patients did not have a documented follow-up plan within the required timeframe.

Diagnostic Testing Timeliness. VHA requires that patients receive diagnostic testing within 60 days of positive CRC screening test results unless contraindicated.[3] Two of the 10 patients who received diagnostic testing did not receive that testing within the required timeframe.

[1] VHA Directive 2007-004, *Colorectal Cancer Screening*, January 12, 2007 (corrected copy).
[2] VHA Directive 2007-004.
[3] VHA Directive 2007-004.

Diagnostic Test Result Notification. VHA requires that test results be communicated to patients no later than 14 days from the date the results are available to the ordering practitioner and that clinicians document notification.[4] None of the 10 patients who received diagnostic testing had documentation of timely notification in their medical records.

Biopsy Result Notification. VHA requires that patients who have a biopsy receive notification of the results within 14 days of the date the biopsy results were confirmed and that clinicians document notification.[5] None of the seven patients who had a biopsy had documentation of timely notification in their medical records.

Recommendations

1. We recommended that processes be strengthened to ensure that patients are notified of positive CRC screening test results within the required timeframe and that clinicians document notification.

2. We recommended that processes be strengthened to ensure that responsible clinicians either develop follow-up plans or document that no follow-up is indicated within the required timeframe.

3. We recommended that processes be strengthened to ensure that patients with positive CRC screening test results receive diagnostic testing within the required timeframe.

4. We recommended that processes be strengthened to ensure that patients are notified of diagnostic test results within the required timeframe and that clinicians document notification.

5. We recommended that processes be strengthened to ensure that patients are notified of biopsy results within the required timeframe and that clinicians document notification.

[4] VHA Directive 2009-019, *Ordering and Reporting Test Results,* March 24, 2009.
[5] VHA Directive 2007-004.

Moderate Sedation

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

We reviewed relevant documents, 12 medical records, and staff training/competency records, and we interviewed key individuals. The areas marked as noncompliant in the table below needed improvement. Details regarding the findings follow the table.

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

Staff Training. VHA requires that non-physician clinical staff in each moderate sedation area complete appropriate training.[6] We reviewed the training records of 17 staff and found that 5 had not completed moderate sedation training.

Pre-Sedation Assessment Documentation. VHA requires that providers document a complete history and physical examination and/or pre-sedation assessment within 30 days prior to a procedure where moderate sedation will be used.[7] We found deficiencies in nine patients' medical records. None of the nine records included all required elements of the history and physical examination, such as airway assessment or documentation of a previous adverse experience with sedation. In addition, four records did not contain assessments of substance abuse, three did not contain a physician re-evaluation immediately prior to the procedure, and two did not contain risk assessments.

Informed Consent. VHA requires that the patient be informed about the procedure and given the name of the provider who will perform the procedure and that consent be completed on the approved form and entered in the medical record.[8] For three patients,

[6] VHA Directive 2006-023, *Moderate Sedation by Non-Anesthesia Providers*, May 1, 2006.
[7] VHA Directive 2006-023.
[8] VHA Handbook 1004.01, *Informed Consent for Clinical Treatments and Procedures,* August 14, 2009.

the providers who performed the procedures were not the providers listed on the consent forms, and there was no evidence in the medical records that the change in providers was discussed with and agreed to by the patients. For two additional patients, consent was completed on a paper form no longer approved for use, and the forms were not scanned into the medical records.

Timeouts. VHA requires that relevant team members, including the provider who will perform the procedure, participate in the pre-procedure timeout.[9] During the timeout we observed, all relevant team members participated, including the provider who was to perform the procedure. However, five patients' medical records did not contain evidence of provider participation in the timeout.

Monitoring of Reversal Agents. VHA requires that the use of moderate sedation reversal agents be monitored and trended.[10] We found that there was not a reliable system in place to record the use of reversal agents. Reversal medications were not part of an automated dispensing system that would allow for medication use tracking and trending. Instead, the facility relied on clinical staff to file an incident report if a reversal agent was used.

Recommendations

6. We recommended that processes be strengthened to ensure that all required staff receive moderate sedation training.

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

8. We recommended that processes be strengthened to ensure that all informed consents are completed appropriately and that any changes to the consents are discussed with and approved by the patients prior to administration of sedation.

9. We recommended that processes be strengthened to ensure that relevant team members document their participation in the pre-procedure timeout.

10. We recommended that processes be strengthened to ensure that a reliable system is in place to monitor and trend the use of reversal agents.

[9] VHA Directive 2010-023, *Ensuring Correct Surgery and Invasive Procedures*, May 17, 2010.
[10] VHA Directive 2006-023.

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 Post-Traumatic Stress Disorder and Substance Abuse RRTPs complied with selected MH RRTP requirements.

We inspected the medical and surgical intensive care, spinal cord injury, medicine/neurology/telemetry, medicine/chemotherapy/telemetry, locked inpatient MH, dialysis, and post-traumatic stress disorder and substance abuse units. We also inspected the ED; the operating room; the rehabilitation and physical therapy department; and the dental, MH/medical, and women's clinics. Additionally, we reviewed facility policies, meeting minutes, training records, and other relevant documents, and we interviewed employees and managers. The areas marked as noncompliant in the table below needed improvement. Details regarding the findings follow the table.

Noncompliant	Areas Reviewed for EOC
X	Patient care areas were clean.
	Fire safety requirements were properly addressed.
X	Environmental safety requirements were met.
	Infection prevention requirements were met.
	Medications were secured and properly stored, and medication safety practices were in place.
	Sensitive patient information was protected.
	If the community living center had a resident animal program, facility policy addressed VHA requirements.
X	Laser safety requirements in the operating room were properly addressed, and users received medical laser safety training.
	The facility complied with any additional elements required by local policy.
	Areas Reviewed for MH RRTP
	There was a policy that addressed safe medication management, contraband detection, and inspections.
X	MH RRTP inspections were conducted, included all required elements, and were documented.
X	Actions were initiated when deficiencies were identified in the residential environment.
	Access points had keyless entry and closed circuit television monitoring.
	Female veteran rooms and bathrooms in mixed gender units were equipped with keyless entry or door locks.
	The facility complied with any additional elements required by local policy.

Cleanliness. The Joint Commission requires that areas used by patients be clean. The ED was extremely dirty. We found several soiled gloves and a dirty gown on the floor and soiled gloves on top of equipment. We also found two open, overloaded non-biohazard trashcans and dirty patient rooms.

Environmental Safety. The Occupational Safety and Health Administration and The Joint Commission require that facilities maintain current MSDS inventory lists and hazardous material information for chemicals used in clinical areas. We reviewed 15 MSDS inventory lists and hazardous material information sheets and found that 11 were not current or complete.

Laser Safety. Local policy and the American National Standards Institute require that laser safety glasses be labeled with optical density values. We inspected 18 laser safety glasses and found that 3 were not labeled with optical density values.

Local policy and the American National Standards Institute require that all laser users be trained on the proper use of this equipment. We reviewed 14 employee training records and found that none of the employees had this training documented for FY 2011.

MH RRTP Deficiency Tracking. VHA requires that facilities initiate appropriate corrective actions when deficiencies are identified during monthly MH RRTP self-inspections and that inspection reports indicate sufficient follow-up and tracking.[11] We reviewed documentation of self-inspections for the months of February, March, April, June, and July 2011. Although unit staff documented performance of the monthly self-inspections, we found they did not consistently initiate corrective actions for identified deficiencies.

MH RRTP Inspections. VHA requires that resident rooms be inspected daily for the physical presence of each resident and for unsecured medications and that public areas be inspected regularly and randomly for contraband.[12] We reviewed documentation of required inspections for the month of August 2011 and found that it did not consistently include all required elements.

Recommendations

11. We recommended that a comprehensive EOC inspection of the ED be conducted and that appropriate actions be taken to correct cleanliness deficiencies.

12. We recommended that processes be strengthened to ensure that MSDS inventory lists and hazardous material information sheets are current and complete.

13. We recommended that processes be strengthened to ensure that all laser safety glasses are labeled with optical density values, that all laser users complete laser safety training, and that compliance be monitored.

14. We recommended that processes be strengthened to ensure that documentation of MH RRTP inspections contains all required elements and that corrective actions are initiated when deficiencies are identified.

[11] VHA Handbook 1162.02, *Mental Health Residential Rehabilitation Treatment Program (MH RRTP)*, December 22, 2010.
[12] VHA Handbook 1162.02.

QM

The purpose of this review was to determine whether VHA facility senior managers actively supported and appropriately responded to QM efforts and whether VHA facilities complied with selected requirements within their QM programs.

We interviewed senior managers and QM personnel, and we evaluated meeting minutes, medical records, and other relevant documents. The area marked as noncompliant in the table below needed improvement. Details regarding the finding follow the table.

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

Noncompliant	Areas Reviewed
	Overall, there was evidence that senior managers were involved in performance improvement over the past 12 months.
	Overall, the facility had a comprehensive, effective QM/performance improvement program over the past 12 months.
	The facility complied with any additional elements required by local policy.

FPPEs. VHA requires that FPPEs be initiated for all newly hired licensed independent practitioners prior to the delivery of care and that FPPE results be reported to the MEC for consideration in making recommendations for privileges.[13] We reviewed the profiles of 10 newly hired licensed independent practitioners and found that only 2 had an FPPE initiated and that the results were not reported to the MEC.

Recommendation

15. We recommended that processes be strengthened to ensure that FPPEs are initiated for all licensed independent practitioners prior to the delivery of care and that FPPE results are reported to the MEC.

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

PRRCs

The purpose of this review was to determine whether the facility had implemented a PRRC and whether VHA required programmatic and clinical elements were in place. VHA directed facilities to fully implement PRRCs by September 30, 2009, or to have a Deputy Under Secretary for Health for Operations and Management approved modification or exception. Facilities with missing PRRC programmatic or clinical elements must have an Office of MH Services' approved action plan or Deputy Under Secretary for Health for Operations and Management approved modification.

We reviewed facility policies and relevant documents, inspected the PRRC, and interviewed employees. The area marked as noncompliant in the table below needed improvement. Details regarding the finding follow the table.

Noncompliant	Areas Reviewed
	A PRRC was implemented and was considered fully designated by the Office of MH Services, or the facility had an approved modification or exception.
	There was an established method for soliciting patient feedback, or the facility had an approved action plan or modification.
	The PRRC met space and therapeutic resource requirements, or the facility had an approved action plan or modification.
X	PRRC staff provided required clinical services, or the facility had an approved action plan or modification.
	The facility complied with any additional elements required by local policy.

Clinical Services. VHA requires a minimum array of clinical services for veterans enrolled in PRRC programs, including individual psychotherapy, social skills training, and wellness programming.[14] The PRRC did not offer individual psychotherapy because none of the current PRRC staff were trained to provide psychotherapy. Staff told us they were unable to refer patients to the MH clinic for this service because individual therapy was not being provided due to staffing shortages. MH managers told us they hoped to fill the vacant PRRC Coordinator position with a psychologist.

Recommendation

16. We recommended that processes be strengthened to ensure that the PRRC offers all required clinical services or that the facility obtains an approved action plan or modification.

[14] VHA Handbook 1160.01, *Uniform Mental Health Services in VA Medical Centers and Clinics,* September 11, 2008.

Polytrauma

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

We reviewed relevant documents, 20 medical records of patients with a positive TBI screening, and 10 staff training records, and we interviewed key staff. The area marked as noncompliant in the table below needed improvement. Details regarding the finding follow the table.

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

Staffing. VHA requires that minimum polytrauma staffing levels be maintained.[15] The facility did not meet the minimum staffing requirement because there was no physiatrist (rehabilitation physician) assigned as Medical Director for the program.

Recommendation

17. We recommended that required polytrauma staffing levels be maintained.

[15] VHA Directive 2009-028, *Polytrauma-Traumatic Brain Injury (TBI) System of Care*, June 9, 2009.

Review Activities Without Recommendations

Coordination of Care

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

We reviewed 30 HF patients' medical records and relevant facility policies, and we interviewed employees. The table below details the areas reviewed. The facility generally met requirements. We made no recommendations.

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

Medication Management

The purpose of this review was to determine whether VHA facilities had properly provided selected vaccinations according to Centers for Disease Control and Prevention guidelines and VHA recommendations.

We reviewed a total of 10 medical records for evidence of screening and administration of tetanus and shingles vaccines to primary care patients. We also reviewed documentation of selected vaccine administration requirements and interviewed key personnel.

The table below shows the areas reviewed for this topic. The facility generally met requirements. We made no recommendations.

Noncompliant	Areas Reviewed
	Staff screened patients for pneumococcal and tetanus vaccinations.
	Staff properly administered pneumococcal and tetanus vaccinations.
	Staff properly documented vaccine administration.
	Vaccines were available for use.
	If applicable, staff provided vaccines as expected by the VISN.
	The facility complied with any additional elements required by local policy.

Comments

The VISN and Facility Directors agreed with the CAP review findings and recommendations and provided acceptable improvement plans. (See Appendixes D and E, pages 21–30 for full text of the Directors' comments.) We consider Recommendation 17 closed. We will follow up on the planned actions for the open recommendations until they are completed.

Facility Profile[16]		
Type of Organization	Tertiary care medical center	
Complexity Level	1a	
VISN	9	
Community Based Outpatient Clinics	Bolivar, TN Byhalia, MS Dyersburg, TN Helena, AR Jackson, TN Jonesboro, AR Memphis, TN (two clinics) Savannah, TN Smithville, MS	
Veteran Population in Catchment Area	196,000	
Type and Number of Total Operating Beds: • **Hospital, including Psychosocial RRTP**	208	
• **Community Living Center/Nursing Home Care Unit**	N/A	
• **Other**	0	
Medical School Affiliation(s)	The University of Tennessee Health Science Center, Memphis, TN	
• **Number of Residents**	120.25	
	Prior FY (2011)	**Prior FY (2010)**
Resources (in millions):		
• **Total Medical Care Budget**	$388	$369
• **Medical Care Expenditures**	$388	$369
Total Medical Care Full-Time Employee Equivalents	2,226.5	2,142.8
Workload:		
• **Number of Station Level Unique Patients**	50,353	52,678
• **Inpatient Days of Care:**		
o **Acute Care**	45,893	30,857
o **Community Living Center/Nursing Home Care Unit**	N/A	N/A
Hospital Discharges	5,356	6,735
Total Average Daily Census (including all bed types)	127.2	145.5
Cumulative Occupancy Rate (in percent)	51.8	66.9
Outpatient Visits	429,902	515,015

[16] All data provided by facility management.

Follow-Up on Previous Recommendations		
Recommendations	**Current Status of Corrective Actions Taken**	**Repeat Recommendation? Y/N**
QM		
1. Require that QM and Performance Improvement Committee minutes reflect documentation of action plans, assign responsibility, track open action items, and monitor implemented changes.	QM has conducted random audits to ensure that action plans are in place and tracked until completion. The Surgical Quality Improvement Committee has restructured. This recommendation is still in progress.	N
2. Ensure that Peer Review Committee minutes address data analysis and tracking of action completion by service.	A tracking system was developed and implemented.	N
3. Require that patient advocate staff analyze patient complaints, determine patterns or trends, and report results quarterly.	A report process is in development, and issues will be tracked and trended to identify effective resolutions. This recommendation is still in progress.	N
4. Ensure that the annual patient safety report to leadership includes analysis of system or process issues.	Reports submitted to leadership reflect data analysis.	N
5. Monitor medication reconciliation at the time of discharge.	A system is in place to capture and monitor medication reconciliation at discharge. This is reported to the VISN.	N
6. Monitor all required items for all resuscitation efforts, and compare data to benchmarks.	The Blue Alert Record was amended to include all requirements related to resuscitation efforts. Data is compared to national benchmarks and reported to the Cardiopulmonary Resuscitation Committee quarterly.	N
7. Have a plan to address the delivery of care to patients held in temporary bed locations.	Facility Policy 11-13, Bed Assignment and Diversion Status, was revised and approved.	N

Recommendations	Current Status of Corrective Actions Taken	Repeat Recommendation? Y/N
Reusable Medical Equipment		
8. Ensure that standard operating procedures for all types of reusable medical equipment are readily available in the decontamination area.	The facility has conducted random audits to ensure standard operating procedures are in place in the decontamination area. Reusable medical equipment reports are presented quarterly to Infection Control Committee and will be reported semi-annually to the Quality Executive Board starting FY 2012.	N
Physician Credentialing and Privileging		
9. Update facility policy to include quality of care triggers for FPPE.	The policy was revised to include triggers that would initiate an FPPE.	N
10. Ensure that provider profiles include FPPE data and that the Credentialing and Privileging Committee conducts follow-up regularly.	The policy was revised to define the process and time intervals for follow-up.	N
11. Ensure that clinical service chiefs define the criteria for delineation of privileges.	The policy was revised to include the criteria for delineation of privileges, and the Medical Staff Bylaws have been amended to reflect required changes.	N
EOC		
12. Ensure that all medication rooms are secured.	Random audits were conducted and showed compliance.	N
13. Ensure that appropriate staff receive annual respirator fit testing.	The Safety Office provides monthly reports to supervisors. Compliance improved from 80 percent to 100 percent by the end of FY 2011.	N
Coordination of Care		
14. Ensure that inter-facility transfers are documented and monitored.	A total of 10 cases are reviewed monthly and reported to the Utilization Management Committee. Documentation monitoring reports reflect compliance.	N

Recommendations	Current Status of Corrective Actions Taken	Repeat Recommendation? Y/N
MRI Safety		
15. Ensure that MRI staff document actions taken to evaluate any positive responses identified on screening questionnaires.	The MRI supervisor continues to review documentation of completed screens with a positive response and verifies data with MRI technicians and radiologists.	N
16. Ensure that MRI safety education is provided during orientation for non-MRI staff who have access to the MRI area.	Training has been provided. The MRI Safety Officer has oversight of MRI safety training.	N

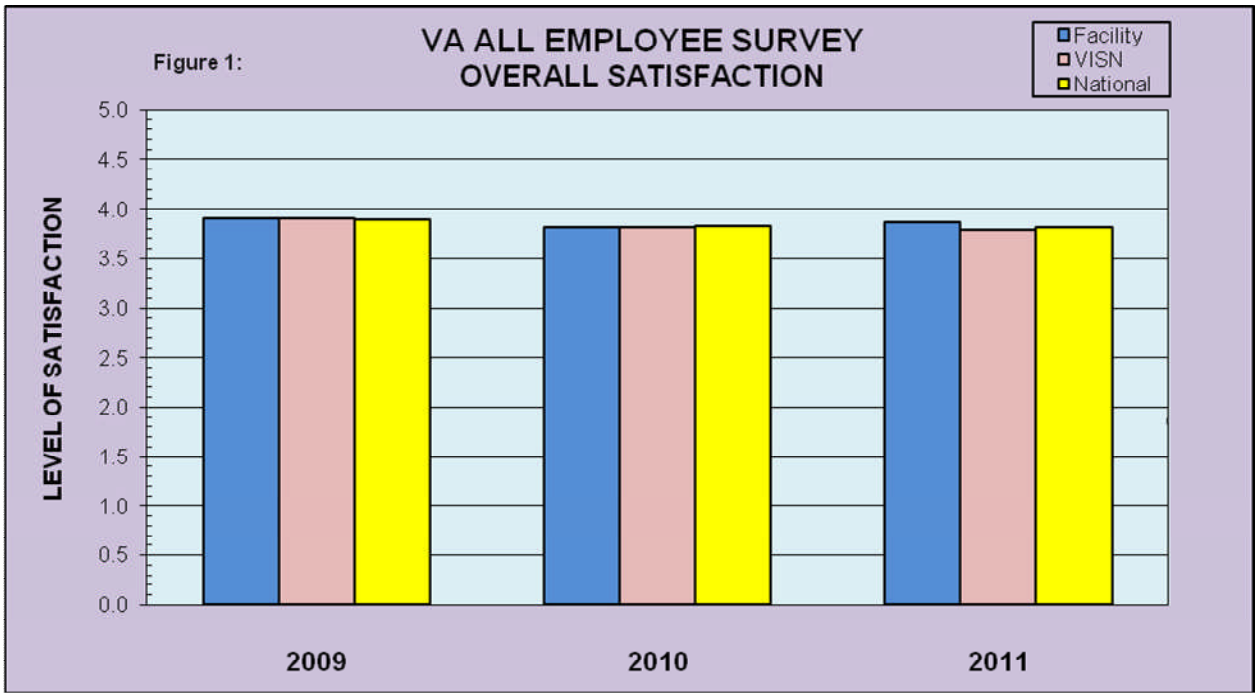
VHA Satisfaction Surveys

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 satisfaction scores and targets for quarters 3–4 of FY 2010 and quarters 1–2 of FY 2011 and overall outpatient satisfaction scores and targets for quarter 4 of FY 2010 and quarters 1–3 of FY 2011.

Table 1

	FY 2010		FY 2011			
	Inpatient Score Quarters 3–4	Outpatient Score Quarter 4	Inpatient Score Quarters 1–2	Outpatient Score Quarter 1	Outpatient Score Quarter 2	Outpatient Score Quarter 3
Facility	57.5	53.6	47.5	51.6	50.7	54.9
VISN	62.9	54.7	62.1	57.1	56.0	55.3
VHA	64.1	54.4	63.9	55.9	55.3	54.2

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 received hospital care.[17] Mortality (or death) rates focus on whether patients died within 30 days of being hospitalized. Readmission rates focus on whether patients were hospitalized again within 30 days of their discharge. These rates are based on people who are 65 and older and are "risk-adjusted" to take into account how sick patients were when they were initially admitted. Table 2 below shows facility and U.S. national Hospital Outcome of Care Measure rates for patients discharged between July 1, 2007, and June 30, 2010.[18]

Table 2

	Mortality			Readmission		
	Heart Attack	Congestive HF	Pneumonia	Heart Attack	Congestive HF	Pneumonia
Facility	19.6	13.9	15.3	24.2	26.0	21.9
U.S. National	15.9	11.3	11.9	19.8	24.8	18.4

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

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

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: December 21, 2011

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

Subject: **CAP Review of the Memphis VA Medical Center, Memphis, TN**

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

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 Office of Inspector General Combined Assessment Program (OIG – CAP) Review conducted October 3–7, 2011.

2. If you have any 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: December 13, 2011

From: Director, Memphis VA Medical Center (614/00)

Subject: **CAP Review of the Memphis VA Medical Center, Memphis, TN**

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

1. Attached please find the VA Medical Center at Memphis' response to the Office of Inspector General Combined Assessment Program (OIG – CAP) Review conducted October 3–7, 2011.

2. If you have any questions regarding the information provided, please contact Jan Slate, Accreditation Manager, Quality Management and Performance Improvement. Mrs. Slate can be reached at (901) 577-7379 menu choice #5.

(original signed by:)
JAMES L. ROBINSON, III, PSY.D
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 processes be strengthened to ensure that patients are notified of positive CRC screening test results within the required timeframe and that clinicians document notification.

Concur

Target date for completion: February 28, 2012

It should be noted that the facility is no longer using the fecal occult blood test but has started the use of the Fecal Immunochemistry Test (FIT). A positive FIT causes a View Alert to be sent from the Lab to the Primary Care Provider. Negative FIT results are found in Patient Aligned Care Team (PACT) record reviews. In PACT for a negative screening result, the patient will be notified by either a letter or a phone call. The clinician who does the patient notification is responsible for the documentation of the patient notification. For a positive screening result a plan is developed by the provider, and the provider calls the patient. The provider who does the patient notification is responsible for the documentation of the patient notification. Ambulatory Care will monitor 30 random positive FIT results in January and February 2012 to ensure the timeliness of this notification process is within 14 days of the Lab View Alert. Corrective action will be initiated as appropriate.

Recommendation 2. We recommended that processes be strengthened to ensure that responsible clinicians either develop follow-up plans or document that no follow-up is indicated within the required timeframe.

Concur

Target date for completion: February 28, 2012

The facility does not do Double Contrast Barium Enemas. For a positive FIT screening result a plan is developed by the provider and documented in the computerized patient record system (CPRS). The provider calls the patient with the FIT results and the follow-up plan. The provider who does the patient notification is responsible for the documentation of the patient notification. Ambulatory Care will monitor 30 random positive FIT results in January and February 2012 to ensure that follow-up plans are documented within 14 days of the Lab View Alert. Corrective action will be initiated as appropriate.

A provider may consult GI for a screening colonoscopy. The GI physician reviews the colonoscopy results, documents findings in CPRS, and notifies the provider. A letter is

sent to the patient from GI with the results and follow-up plan. The GI physician initiates a consult to surgery and radiology CT as appropriate. GI/Medical Service staff will monitor 30 random positive colonoscopies in January and February 2012 to ensure that follow-up plans are documented within 14 days of the screening colonoscopy. Corrective action will be initiated as appropriate.

Recommendation 3. We recommended that processes be strengthened to ensure that patients with positive CRC screening test results receive diagnostic testing within the required timeframe.

Concur

Target date for completion: March 31, 2012

When the provider receives notification of a positive FIT, the provider will consult GI for colonoscopy. The GI procedure is scheduled in-house or outsourced to the GI contract provider. The GI physician initiates consults to surgery and radiology CT if results from a screening colonoscopy require further intervention. Medical Service will monitor GI consults to ensure patients with positive CRC screening test results receive diagnostic testing within 60 days.

Recommendation 4. We recommended that processes be strengthened to ensure that patients are notified of diagnostic test results within the required timeframe and that clinicians document notification.

Concur

Target date for completion: April 20, 2012

All colonoscopies completed result in a plan of care being developed by the VA Memphis GI physician. The GI physician will: (1) initiate a Surgery and CT Consult; (2) determine if the Veteran needs to be re-scoped earlier than normally recommended; or (3) determine the Veteran does not need to be re-scoped until normally recommended. The GI physician completes the “Colonoscopy Template” and adds the provider as a co-signer to the template. The GI physician sends a letter to the Veteran and documents this on the Colonoscopy Template. GI clinic staff sends the letter to the patient.

Recommendation 5. We recommended that processes be strengthened to ensure that patients are notified of biopsy results within the required timeframe and that clinicians document notification.

Concur

Target date for completion: April 20, 2012

All colonoscopies completed result in a plan of care being developed by the VA Memphis GI physician. The GI physician will: (1) initiate a Surgery and CT Consult; and

(2) determine if the Veteran needs to be re-scoped earlier than normally recommended. The GI physician completes the "Colonoscopy Template" and adds the provider as a co-signer to the template. The GI physician sends a letter to the Veteran and documents this on the Colonoscopy Template. GI clinic staff sends the letter to the patient.

Recommendation 6. We recommended that processes be strengthened to ensure that all required staff receive moderate sedation training.

Concur

Target date for completion: January 31, 2012

Nurse Managers of the Moderate Sedation areas will ensure that all staff performing moderate sedation will complete the required training. The online VA training module, Moderate Sedation In-service Training Program, will be assigned as a required annual training in TMS for each nurse performing moderate sedation. For any staff who have not completed the training (as noted in this report), training will be completed by January 31, 2012.

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

Concur

Target date for completion: Completed September 30, 2011

In September 2011 the Chief, Anesthesiology and IT Staff completed revisions to the Moderate Sedation Template in CPRS. Additional fields were added in the template to ensure providers documented the pre-sedation assessment with elements required in VHA Directive 2006-023. Other fields in the template were made mandatory fields to ensure nurse pre-sedation documentation was completed as well as timeout requirements. The timeout portion of the template requires a listing of those participating in the timeout. Training for staff in the moderate sedation treatment areas was conducted by the Chief of Anesthesiology on September 28, 2011. During this OIG CAP review of October 2011, the CAP surveyor was complimentary of the thoroughness of the revised template. The medical center memorandum Use of Sedation and Analgesia, 11-35, was updated September 23, 2011, to reflect the changes/requirements in the Moderate Sedation Template.

Recommendation 8. We recommended that processes be strengthened to ensure that all informed consents are completed appropriately and that any changes to the consents are discussed with and approved by the patients prior to administration of sedation.

Concur

Target date for completion: January 31, 2012

If the situation arises such that the provider named on a consent form is not the provider that will perform the procedure, the RN of the moderate sedation area will document the change in provider as well as the patient agreement to the change. At times when a paper consent form must be used, e.g., in Interventional Radiology, the medical center will ensure the correct form, 10-431a, Consent for Clinical Treatment or Procedure, is in the appropriate area for use if needed. RN staff in the moderate sedation areas are responsible for ensuring that any paper consent form is scanned into CPRS.

Recommendation 9. We recommended that processes be strengthened to ensure that relevant team members document their participation in the pre-procedure timeout.

Concur

Target date for completion: Completed September 30, 2011

In September 2011 the Chief of Anesthesiology and IT Staff completed revisions to the Moderate Sedation Template in CPRS. Additional fields were added in the template to ensure providers documented the pre-sedation assessment with elements required in VHA Directive 2006-023. Other fields in the template were made mandatory fields to ensure nurse pre-sedation documentation was completed as well as timeout requirements. The timeout portion of the template requires a listing of those participating in the timeout. Training for staff in the moderate sedation treatment areas was conducted by the Chief, Anesthesiology on September 28, 2011. During this OIG CAP review of October 2011, the CAP surveyor was complimentary of the thoroughness of the revised template. The medical center memorandum Use of Sedation and Analgesia, 11-35, was updated September 23, 2011, to reflect the changes/requirements in the Moderate Sedation Template.

Recommendation 10. We recommended that processes be strengthened to ensure that a reliable system is in place to monitor and trend the use of reversal agents.

Concur

Target date for completion: Completed December 12, 2011

Effective December 12, 2011, all reversal agents will be pulled from the moderate sedation areas and be dispensed via the MedSelect (Diebold) system providing a tracking system for agents used. Pharmacy Service will pull a list of reversal agents removed from the MedSelect unit every day. The Chief of Anesthesiology will review cases where reversal agents are used and generate a monthly report tracking the use of reversal agents by area and by provider. Results of reversal agent usage will be reported to the Clinical Executive Board.

Recommendation 11. We recommended that a comprehensive EOC inspection of the ED be conducted and that appropriate actions be taken to correct cleanliness deficiencies.

Concur

Target date for completion: December 21, 2011

A comprehensive review by the full EOC Rounds Committee was completed in the ED on November 15 and November 17, 2011, as part of the regularly scheduled EOC Rounds. The EOC Rounds Committee members include the Associate Director; Biomed; Customer Service; Environmental Management Service; Engineering Service; Fire Safety; GEMS; Information Security Office; Infection Control; Logistics Service; Nursing Service; Office of Information &Technology; Police Service; Privacy Officer; Patient Safety; SPD; Safety Officer; Women's Veteran's Patient Manager.

The plan is to conduct an additional comprehensive review of the ED in December by a smaller group of EOC Rounds Committee members to ensure the safety and cleanliness of this area for patients, staff and visitors. The members identified for this review will be Engineering Service; Environmental Management Service; Infection Control; Patient Safety; and Safety Officer. If deficiencies are noted, this will be followed until resolution by this review group and reported in the EOC Rounds Committee. The ED will also continue to be included in the regularly scheduled EOC Rounds.

Recommendation 12. We recommended that processes be strengthened to ensure that MSDS inventory lists and hazardous material information sheets are current and complete.

Concur

Target date for completion: March 1, 2012

Environmental Health and Safety Staff (EH&S) have been in the process of addressing this topic prior to and since the OIG CAP review. The following actions have been/will be implemented:

1. On October 28, 2011, a contract was awarded to assist the EH&S staff in transferring the current system into an electronic database that resides within the VHA Center for Engineering and Occupational Safety and Health (CEOSH) that all staff in the Medical Center will be able to access.

2. As of November 30, 2011, all hazardous material inventories have been updated and a current inventory list placed in each binder.

3. The contractor is currently on site working to verifying accuracy of inventories and MSDSs. This will be completed by December 16, 2011.

4. All service inventories will be uploaded into the CESOH database system by January 13, 2012.

5. Effective January 30, 2012, a hard copy master inventory and MSDS binders will be maintained at the MAA Office as a contingency plan in the event of an emergency.

6. All staff will be provided training on how to access and utilize the new database system by March 1, 2012.

Recommendation 13. We recommended that processes be strengthened to ensure that all laser safety glasses are labeled with optical density values, that all laser users complete laser safety training, and that compliance be monitored.

Concur

Target date for completion: Completed December 9, 2011

The three glasses that were not labeled with optical density values were removed from the laser safety cart immediately, which houses the laser safety glasses and laser safety signs. These three glasses are used for radiation protection during fluoroscopy procedures and are not to be used for laser procedures; hence they are not required to be labeled with a laser wavelength. In an effort to reduce confusion, a special case will be provided and designated to keep the radiation safety glasses. A special case will also be provided and designated to keep the laser safety eyewear. This was completed December 9, 2011.

The Laser Safety Officer respectfully submits that training was provided to employees in the 2010 calendar year and had been previously scheduled and was provided on October 5, 2011 (during the CAP Survey). This satisfies the local Laser Safety Policy, Memorandum 00-60, which states in part*, the Laser Safety Committee will maintain an effective and appropriate laser-training program for staff.* In an effort to reduce confusion, the Laser Safety Officer has adjusted the laser training schedule for staff to coincide with the VA fiscal year training schedule instead of the calendar year. The comprehensive laser training schedule will now include a list of individuals categorized by service and completed training date. The schedule will be posted in the Radiation Safety SharePoint site on December 9, 2011. The Laser Safety Officer will monitor the training schedule monthly and send reminders, via email, to remind individuals. Compliance will be reported and monitored as a standard reporting item in the Laser Safety Committee minutes. This change will be communicated to the Laser Safety Committee members on December 9, 2011.

Recommendation 14. We recommended that processes be strengthened to ensure that documentation of MH RRTP inspections contains all required elements and that corrective actions are initiated when deficiencies are identified.

Concur

Target date for completion: January 31, 2012

During the survey it was noted that the MH RRTP monthly inspection process contained the required elements; however, the corrective actions did not document issue resolution. This documentation requirement has been incorporated into the monthly process. For the inspections in October and November, the rounds did not reflect deficiencies.

Daily inspections of the resident rooms/public areas do occur with documentation of the daily rounds noted on the Daily Observation Form. This form allows documentation of the daily inspections of: (1) the presence of the resident; (2) resident rooms to include review of the closet space and check for unsecured medications; and (3) all public areas. The use of the form will be revised to include documentation of any discrepancies found on the reverse side of the form. Therefore, if discrepancies are found, notation to the initiation of action and follow-up to resolution will be all on one form. Staff will be educated on the revised documentation process and the new process will be in place January 31, 2012.

Recommendation 15. We recommended that processes be strengthened to ensure that FPPEs are initiated for all licensed independent practitioners prior to the delivery of care and that FPPE results are reported to the MEC.

Concur

Target date for completion: January 2012.

Currently, each month the Medical Staff Office provides a list of newly appointed providers to the Service Chief, Service Secretary, and Service Administrative Assistant via the Credentialing and Privileging (C&P) Committee Minutes. This provides notice to the service of the need for initiation of the FPPE. Effective with the January 2012 C&P Committee, the names of the new providers will be added to the Committee Agenda five months from initiation of privileges to serve as reminder that the FPPE is due the following month. At six months, the FPPE is reported to both the C&P Committee and the MEC as completed or that an extension is requested. The C&P Committee report to the MEC includes delinquent FPPEs. All Service Chiefs are members of MEC. If at 6 months the FPPE is not completed, the Service Chief will be asked during MEC to respond.

Recommendation 16. We recommended that processes be strengthened to ensure that the PRRC offers all required clinical services or that the facility obtains an approved action plan or modification.

Concur

Target date for completion: Position will be posted by December 21, 2011.

The facility is in process of hiring a PRRC Coordinator to fill the current vacancy and will have the position posted by December 21. The Coordinator position will be recruited as a Psychologist, Licensed Clinical Social Worker (LCSW), or Advanced Practice Nurse. This will ensure the delivery of individual psychotherapy services as required. In the interim, to ensure appropriate services are available to our Veterans, a LCSW is providing individual psychotherapy services where need is most critical.

Recommendation 17. We recommended that required polytrauma staffing levels be maintained.

Concur

Target date for completion: Completed December 1, 2011

We continue to recruit for a 0.5 FTEE physiatrist. In the meantime, we have designated Dr. Carlos Cyrus, a physiatrist, 0.5 FTEE as Medical Director of Polytrauma Program as required by the Directive.

OIG Contact and Staff Acknowledgments

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