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

**Office of Healthcare Inspections**

**Report No. 11-03667-108**

# Combined Assessment Program Review of the VA Roseburg Healthcare System Roseburg, Oregon

**March 13, 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 |
| CLC | community living center |
| CRC | colorectal cancer |
| EOC | environment of care |
| facility | VA Roseburg Healthcare System |
| FPPE | Focused Professional Practice Evaluation |
| FY | fiscal year |
| HF | heart failure |
| MH RRTP | Mental Health Residential Rehabilitation Treatment Program |
| MM | medication management |
| MRC | Medical Record Committee |
| OIG | Office of Inspector General |
| PTSD | post-traumatic stress disorder |
| QM | quality management |
| SA | substance abuse |
| TBI | traumatic brain injury |
| VHA | Veterans Health Administration |
| VISN | Veterans Integrated Service Network |

# Table of Contents

# Executive Summary: Combined Assessment Program Review of the VA Roseburg Healthcare System, Roseburg, OR

**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 November 28, 2011.

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

- Coordination of Care

The facility's reported accomplishments were establishing a successful Cardiac Risk Reduction Clinic and implementing a "no-lift" policy.

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

*Quality Management:* Report Focused Professional Practice Evaluation results to the Medical Executive Committee. Complete medical record quality reviews, and ensure the Medical Record Committee provides oversight and coordination. Monitor the copy and paste functions.

*Environment of Care:* Secure soiled utility rooms and biohazardous waste containers. Perform annual preventive maintenance on the community living center's elopement prevention system. Ensure laser users complete laser safety training. Alarm the back egress in the substance abuse/post-traumatic stress disorder unit.

*Colorectal Cancer Screening:* Notify patients of positive screening and diagnostic test results within the required timeframe. Develop follow-up plans within the required timeframe.

*Moderate Sedation:* Complete pre-sedation assessment documentation, and include all required elements. Use checklists for all timeouts.

*Medication Management:* Screen patients for vaccinations, administer vaccinations when indicated, and document all required vaccination administration elements.

*Polytrauma:* Ensure patients with positive traumatic brain injury screens receive a comprehensive evaluation as outlined in policy.

*Follow-Up on Community Living Center Monthly Medication Reviews:* Ensure pharmacists consistently perform and document monthly medication reviews.

## Comments

The Veterans Integrated Service Network and Facility Directors agreed with the Combined Assessment Program review findings and recommendations and provided acceptable improvement plans. We will follow up on the planned actions until they are completed.

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

# Objectives and Scope

## Objectives

CAP reviews are one element of the OIG's efforts to ensure that our Nation's veterans receive high quality VA health care services. The objectives of the CAP review are to:

- Conduct recurring evaluations of selected health care facility operations, focusing on patient care administration and QM.
- Provide crime awareness briefings to increase employee understanding of the potential for program fraud and the requirement to refer suspected criminal activity to the OIG.

## Scope

We reviewed selected clinical and administrative activities to evaluate the effectiveness of patient care administration and QM. Patient care administration is the process of planning and delivering patient care. QM is the process of monitoring the quality of care to identify and correct harmful and potentially harmful practices and conditions.

In performing the review, we inspected selected areas, interviewed managers and employees, and reviewed clinical and administrative records. The review covered the following eight activities:

- Coordination of Care
- CRC Screening
- EOC
- Follow-Up on CLC Monthly Medication Reviews
- MM
- Moderate Sedation
- Polytrauma
- 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 and FY 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 VA Roseburg Healthcare System, Roseburg, Oregon,* Report No. 09-02921-57, January 5, 2010). (See Appendix B for further details.) The facility had a repeat finding in the area of CLC monthly medication reviews (formerly part of the MM review).

During this review, we also presented crime awareness briefings for 41 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 186 responded. Survey results were shared with facility managers.

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

# Reported Accomplishments

## Cardiac Risk Reduction Clinic

In 2004, the facility started a Cardiac Risk Reduction Clinic staffed by pharmacy employees. Of the patients active in the clinic during the past year, 60.4 percent have reached their low-density lipoprotein[1] goal compared to 38.2 percent at baseline. Similarly, 58.5 percent of the patients active in the clinic have reached their hemoglobin A1c goal compared to 33.9 percent at baseline.

## EOC "No-Lift" Policy

In FY 2009, the facility implemented a "no-lift" policy to minimize employee injuries. As a result, a performance improvement team was established to analyze injury data and lifting procedures, address patient lift needs, and formulate a strategy for correction. In FY 2008, the facility had 17 injuries resulting in 333 lost days and $53,251 in compensation. In FY 2010, the number of injuries decreased to only three with no lost days and only $3,119 in compensation.

[1] LDL.

# Results

## Review Activities With Recommendations

### 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 areas marked as noncompliant in the table below needed improvement. Details regarding the findings 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. |
| X | 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. |
| X | Copy and paste function monitoring complied with selected requirements. |
| | The patient safety reporting mechanisms and incident analysis complied with policy. |

| Noncompliant | Areas Reviewed |
|---|---|
| | 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. |
| | 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 the results from FPPEs be reported to the Medical Executive Committee for consideration in making the recommendation on privileges for newly hired licensed independent practitioners.[2] We reviewed the profiles of nine newly hired licensed independent practitioners and found that none of the results of the completed FPPEs had been reported to the Medical Executive Committee.

Medical Record Review. VHA requires facilities to have an MRC that provides oversight of medical record quality reviews, which includes analyzing aggregated data.[3] The reviews must include a representative sample of charts from each service or program to ensure that appropriate documentation is occurring. We found that the MRC provided inconsistent oversight and coordination and did not analyze or trend aggregated data. Although some medical record quality reviews had been completed (for example, occupational therapy and physical therapy), we found minimal evidence of medical record quality reviews for physicians.

Copy and Paste Function Monitoring. VHA requires facilities to monitor the copy and paste functions in the electronic medical record.[4] There was no evidence over the past 12 months that the MRC had discussed copy and paste data.

## Recommendations

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

**2.** We recommended that processes be strengthened to ensure that the MRC provides consistent oversight and coordination of medical record quality reviews and that medical record quality reviews are completed, analyzed, and trended for all providers, including physicians.

**3.** We recommended that processes be strengthened to ensure that the MRC monitors the copy and paste functions.

[2] VHA Handbook 1100.19, Credentialing and Privileging, November 14, 2008.
[3] VHA Handbook 1907.01, *Health Information Management and Health Records*, August 25, 2006.
[4] VHA Handbook 1907.01.

## EOC

The purpose of this review was to determine whether the facility maintained a safe and clean health care environment in accordance with applicable requirements and whether the facility's SA and PTSD programs complied with selected MH RRTP requirements.

We inspected the medical unit, the CLC, the locked behavioral health unit, the emergency department, the dental clinic, ophthalmology, primary care, the operating room, and the SA/PTSD MH RRTP unit. 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 |
|---|---|
| | 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 CLC 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. |
| | MH RRTP inspections were conducted, included all required elements, and were documented. |
| | Actions were initiated when deficiencies were identified in the residential environment. |
| X | 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. |

Environmental Safety. The Joint Commission requires that safety and security risks in the environment be minimized or eliminated. We found unlocked soiled utility rooms on two units and biohazardous waste containers on shelves outside patient exam rooms. Soiled utility rooms and biohazardous waste containers contain potentially dangerous items that should be restricted from public access.

VHA requires that preventive maintenance be performed annually on elopement prevention systems in CLCs.[5] Annual preventive maintenance was not done on the elopement prevention system in the CLC.

Laser Safety Training. The Joint Commission requires that all laser users be trained on the proper use of this equipment. We reviewed five employee training records and found that one record did not have this training documented for FY 2011.

MH RRTP General Safety. VHA requires that all MH RRTP access points have keyless entry and closed circuit television monitoring and be alarmed.[6] The back egress in the SA/PTSD unit was not alarmed.

## Recommendations

**4.** We recommended that processes be strengthened to ensure that soiled utility rooms and biohazardous waste containers are secured from public access.

**5.** We recommended that processes be strengthened to ensure that annual preventive maintenance is performed on the CLC's elopement prevention system.

**6.** We recommended that all laser users complete laser safety training and that training be documented.

**7.** We recommended that the back egress in the SA/PTSD unit be alarmed.

[5] VHA Directive 2010-052, *Management of Wandering and Missing Patients*, December 3, 2010.
[6] VHA Handbook 1162.02 , *Mental Health Residential Rehabilitation Treatment Program (MH RRTP),* December 22, 2010.

## 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 17 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. |
| | Patients received a diagnostic test within the required timeframe. |
| X | Patients were notified of the diagnostic test results within the required timeframe. |
| | 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 CRC screening test results within 14 days of the laboratory receipt date for fecal occult blood tests or the test date for sigmoidoscopy or double contrast barium enema and that clinicians document notification.[7] Eight 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.[8] Seven patients did not have a documented follow-up plan within the required timeframe.

Diagnostic Test Result Notification. VHA requires that test results be communicated to patients no later than 14 days from the date on which the results are available to the ordering practitioner and that clinicians document notification.[9] Two of the eight patients who received diagnostic testing did not have documented evidence of timely notification in their medical records.

[7] VHA Directive 2007-004, *Colorectal Cancer Screening*, January 12, 2007 (corrected copy).
[8] VHA Directive 2007-004.
[9] VHA Directive 2009-019, *Ordering and Reporting Test Results*, March 24, 2009.

## Recommendations

**8.** 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.

**9.** 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.

**10.** 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.

## 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, six medical records, and three 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 |
|---|---|
| | Staff completed competency-based education/training prior to assisting with or providing moderate sedation. |
| X | Pre-sedation documentation was complete. |
| | 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. |
| | 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. |

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.[10] We found inconsistent documentation of history and physical examination required elements, such as current medications and time and nature of last oral intake. Additionally, in two of the medical records, the history and physical examination was not completed within 30 days of the procedure.

Timeouts. VHA requires that a timeout be facilitated by a checklist.[11] While we were onsite, we observed a timeout that did not include the use of a checklist.

### Recommendations

**11.** We recommended that processes be strengthened to ensure that pre-sedation assessment documentation is completed within the required timeframe and includes all required elements.

**12.** We recommended that processes be strengthened to ensure that checklists are used for all timeouts.

[10] VHA Directive 2006-023, *Moderate Sedation by Non-Anesthesia Providers*, May 1, 2006.
[11] VHA Directive 2010-023, *Ensuring Correct Surgery and Invasive Procedures*, May 17, 2010.

## MM

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 50 medical records for evidence of screening and administration of pneumococcal vaccines to CLC residents and screening and administration of tetanus and shingles vaccines to CLC residents and primary care patients. We also reviewed documentation of selected vaccine administration requirements and interviewed key personnel.

The areas marked as noncompliant in the table below needed improvement. Details regarding the findings follow the table.

| Noncompliant | Areas Reviewed |
|---|---|
| X | Staff screened patients for pneumococcal and tetanus vaccinations. |
| X | Staff properly administered pneumococcal and tetanus vaccinations. |
| X | 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. |

Vaccination Screening. Through its clinical reminders, VHA requires that clinicians screen patients for pneumococcal and tetanus vaccinations at key points, such as upon admission to a CLC and at clinic visits. Two of 10 records reviewed for pneumococcal vaccination screening lacked documentation of that screening.

Vaccination Administration. The Centers for Disease Control and Prevention recommends that when indicated, clinicians administer pneumococcal and tetanus vaccinations. Two of 10 records reviewed for pneumococcal vaccination administration lacked documentation that indicated vaccinations had been administered.

Vaccination Documentation. Federal law requires that documentation for administered vaccinations include specific elements, such as the vaccine manufacturer and lot number of the vaccine used. Clinicians did not document all required elements in 4 of 10 records reviewed.

### Recommendations

**13**. We recommended that processes be strengthened to ensure that clinicians screen patients for pneumococcal vaccinations upon admission and at clinic visits.

**14.** We recommended that processes be strengthened to ensure that clinicians administer pneumococcal vaccinations when indicated.

**15.** We recommended that processes be strengthened to ensure that clinicians document all required vaccination administration elements and that compliance is monitored.

## 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, 10 medical records of patients with positive TBI results, and 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. |
| X | Providers performed timely, comprehensive evaluations of patients with positive screenings in accordance with VHA policy. |
| | Case Managers were appropriately assigned to outpatients and provided frequent, timely communication. |
| | Outpatients who needed interdisciplinary care had treatment plans developed that included all required elements. |
| | 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-TBI System of Care facilities provided an appropriate care environment. |
| | The facility complied with any additional elements required by local policy. |

Comprehensive Evaluation. VHA requires that patients with positive TBI screening results at a Level IV site be offered further evaluation and treatment by clinicians with expertise in the area of TBI.[12] A higher level Polytrauma System of Care site must complete the comprehensive evaluation, or a Level IV site can develop and submit an alternate plan for review by the VISN and the national Director of Physical Medicine and Rehabilitation for approval of alternate arrangements outside of the directive.

We reviewed the medical records of 10 patients who screened positive for TBI and found that the patients received the comprehensive evaluation at the facility and were not referred to a higher level Polytrauma System of Care site. Additionally, the facility did not have an alternate plan approved by the VISN and the national Director of Physical Medicine and Rehabilitation.

[12] VHA Directive 2010-012, *Screening and Evaluation of Possible Traumatic Brain Injury in Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF) Veterans*, March 8, 2010.

## Recommendation

**16.** We recommended that processes be strengthened to ensure that patients with positive TBI screening results receive a comprehensive evaluation as outlined in VHA policy.

# Review Activity With Previous CAP Recommendations

## Follow-Up on CLC Monthly Medication Reviews

Accreditation standards require that a pharmacist review each CLC patient's medication each month to identify any problems, such as interactions or duplications. As a follow-up to a recommendation from our prior CAP review, we reassessed facility compliance with CLC monthly medication reviews. Pharmacists did not consistently perform and document monthly medication reviews for the 12 CLC patients whose records we reviewed.

### Recommendation

**17**. We recommended that pharmacists consistently perform and document CLC monthly medication reviews.

# Review Activity 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. |

# 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 21–27, for the full text of the Directors' comments.) We will follow up on the planned actions until they are completed.

| Facility Profile[13] | | |
|---|---|---|
| **Type of Organization** | VA medical center | |
| **Complexity Level** | 3 | |
| **VISN** | 20 | |
| **Community Based Outpatient Clinics** | Eugene, OR<br>North Bend, OR<br>Brookings, OR<br>Crescent City, CA | |
| **Veteran Population in Catchment Area** | 62,214 | |
| **Type and Number of Total Operating Beds:**<br>• **Hospital**<br>• **Psychosocial Residential Rehabilitation Treatment Program** | <br>39<br>30 | |
| • **CLC/Nursing Home Care Unit** | 45 | |
| • **Other** | 0 | |
| **Medical School Affiliation(s)** | Pacific University (optometry) | |
| • **Number of Residents** | 0 | |
| | **Prior FY (2011)** | **Prior FY (2010)** |
| **Resources (in millions):** | | |
| • **Total Medical Care Budget** | $168.2 | $145.2 |
| • **Medical Care Expenditures** | $154.3 | $146.3 |
| **Total Medical Care Full-Time Employee Equivalents** | 831.9 | 814.7 |
| **Workload:** | | |
| • **Number of Station Level Unique Patients** | 28,282 | 28,028 |
| • **Inpatient Days of Care:** | | |
| o **Acute Care** | 6,962.00 | 8,593.24 |
| o **CLC/Nursing Home Care Unit** | 14,115.40 | 13,823.96 |
| **Hospital Discharges** | 1,793 | 1,955 |
| **Total Average Daily Census (including all bed types)** | 74.0 | 77.4 |
| **Cumulative Occupancy Rate (in percent)** | 61.18 | 63.99 |
| **Outpatient Visits** | 243,735 | 235,929 |

[13] 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 comprehensive QM program documentation, monitoring, and tracking and timely reporting to designated oversight committees. | Developed action plans were implemented, and the intent for ensuring comprehensive QM program documentation, monitoring, tracking, and timely reporting has been met. | N |
| 2. Require that the recently adopted Ongoing Professional Practice Evaluation and FPPE plans are fully implemented. | For FY 2011, the FPPE and Ongoing Professional Practice Evaluation data for all of the providers were collected and reviewed in a timely manner. | N |
| **MM** | | |
| 3. Require that nurses consistently document the effectiveness of PRN (as needed) pain medications within the required timeframe of the local policy. | Local policy has been revised, and nurses are monitored on documentation of PRN effectiveness through monthly chart reviews. Results are reported at the monthly Executive Council of Nurses meeting. | N |
| 4. Require that pharmacists consistently perform and document CLC monthly medication reviews. | A template was developed to assist the pharmacist with efficiently documenting review findings in patients' electronic medical records. The pharmacist is now doing this on 100 percent of all CLC patients. This is being monitored by chart reviews, and the data are discussed monthly at the Geriatric and Extended Care Committee. | Y (see page 14) |
| **Contracted/Agency Registered Nurses** | | |
| 5. Require nursing managers to validate that contracted/agency registered nurses have completed mandatory training, have presented evidence of clinical competence, and have documentation of completed background investigations prior to providing patient care. | Contract nurses have not been employed since the CAP review in September 2009 nor are there plans to hire contract nurses. | N |

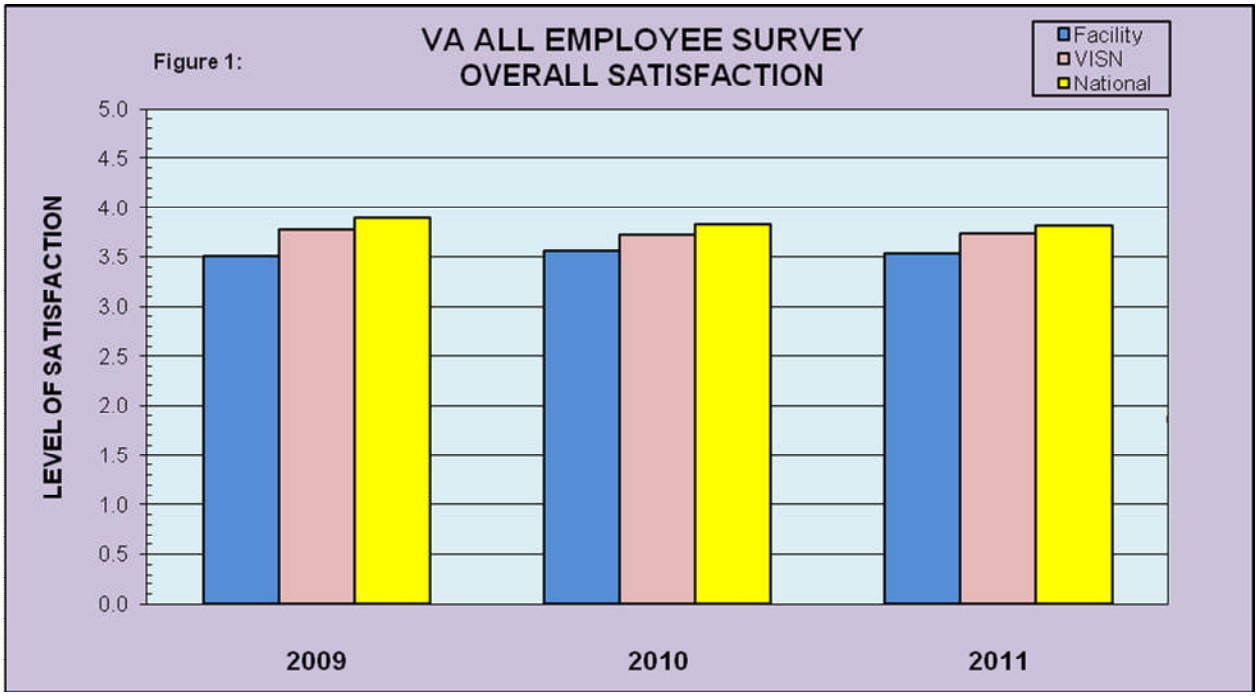
# VHA Satisfaction Surveys

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 | 69.2 | 47.9 | 64.2 | 44.6 | 46.0 | 46.8 |
| VISN | 67.2 | 50.1 | 61.6 | 49.4 | 47.6 | 46.4 |
| 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.[14] 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.[15]

**Table 2**

| | Mortality | | | Readmission | | |
|---|---|---|---|---|---|---|
| | Heart Attack | Congestive HF | Pneumonia | Heart Attack | Congestive HF | Pneumonia |
| Facility | ** | 11.0 | 10.6 | ** | 24.9 | 18.3 |
| U.S. National | 15.9 | 11.3 | 11.9 | 19.8 | 24.8 | 18.4 |

** The number of cases is too small (fewer than 25) to reliably tell how well the facility is performing.

[14] 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.

[15] 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:** February 14, 2012

**From:** Network Director, VISN 20 (10N20)

**Subject:** **CAP Review of the VA Roseburg Healthcare System, Roseburg, OR (653/00)**

**To:** Director, Management Review Service (VHA 10A4A4)

Director, OIG Healthcare (54Q)

Director, Seattle Region, Office of Healthcare Inspections (54SE)

1. Thank you for the opportunity to provide a status report on follow-up to the findings from the Combined Assessment Program Review of the VA Roseburg Healthcare System, Roseburg, Oregon.

2. Attached please find the facility concurrences and responses to each of the findings from the review.

3. If you have additional questions or need further information, please contact Susan Gilbert, Survey Coordinator, VISN 20 at (360) 567-4678

*(original signed by:)*
Susan Pendergrass, DrPH

# Facility Director Comments

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

**Date:** February 15, 2012

**From:** Director, VA Roseburg Healthcare System (653/00)

**Subject:** **CAP Review of the VA Roseburg Healthcare System, Roseburg, OR**

**To:** VISN Director, Northwest Network (10N20)

1. On behalf of the VA Roseburg Healthcare System, Roseburg, Oregon, I would like to express my appreciation to the Office of the Inspector General (OIG) Survey Team for their comprehensive Combined Assessment Program (CAP) review conducted November 28 through December 1, 2011.

2. We have reviewed the findings from the report. The facility responses addressing each recommendation are attached. The responses include actions that are in progress and those that have already been completed.

3. Please feel free to contact us if you have any concerns or questions regarding the responses.

*(original signed by:)*
Carol S. Bogedain, FACHE
Director, VA Roseburg Healthcare System

# Comments to OIG's Report

The following Director's comments are submitted in response to the recommendations in the OIG report:

**OIG Recommendations**

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

Concur

Target date for completion: February 29, 2012

Results of completed FPPEs will be included in Professional Standards Board (PSB) reports to the Executive Committee of the Medical Staff (ECMS). PSB reports will be reviewed to ECMS to ensure FPPE results are included.

**Recommendation 2.** We recommended that processes be strengthened to ensure that the MRC provides consistent oversight and coordination of medical record quality reviews and that medical record quality reviews are completed, analyzed, and trended for all providers, including physicians.

Concur

Target date for completion: July 31, 2012

Medical Records Review Committee will conduct quarterly medical record quality reviews. The medical record quality reviews will include analyzed and trended data for all providers, including physicians.

**Recommendation 3.** We recommended that processes be strengthened to ensure that the MRC monitors the copy and paste functions.

Concur

Target date for completion: July 31, 2012

The Medical Record Committee will review and analyze copy and paste data on a quarterly basis.

**Recommendation 4.** We recommended that processes be strengthened to ensure that soiled utility rooms and biohazardous waste containers are secured from public access.

Concur

Target date for completion: Completed January 24, 2012

Biohazardous waste containers were relocated to locked soiled utility rooms to secure them from public access.

**Recommendation 5.** We recommended that processes be strengthened to ensure that annual preventive maintenance is performed on the CLC's elopement prevention system.

Concur

Target date for completion: Completed December 1, 2011

Preventive maintenance on the CLC's elopement prevention system was completed while the OIG was on site. An annual preventive maintenance schedule was created to ensure that preventive maintenance continues to be completed on an annual basis.

**Recommendation 6.** We recommended that all laser users complete laser safety training and that training be documented.

Concur

Target date for completion: February 29, 2012

Laser users were identified and safety training was assigned to all users. The Laser Safety Committee will monitor and document completion of training.

**Recommendation 7.** We recommended that the back egress in the SA/PTSD unit be alarmed.

Concur

Target date for completion: March 30, 2012

An alarm for the back egress door in the SA/PTSD unit will be installed.

**Recommendation 8.** 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: April 1, 2012

A process guide for patient notification of positive CRC screening test results will be implemented. Chart reviews will be conducted to ensure that patients are notified of positive CRC screening test results within the required timeframe and that clinicians document notification.

**Recommendation 9.** 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: April 1, 2012

A process guide will be implemented for documentation of a plan or document no follow-up is indicated within the required timeframe. Chart reviews will be conducted to ensure documentation.

**Recommendation 10.** 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 1, 2012

A process guide for patient notification will be implemented for diagnostic test results within the required timeframe and that clinicians document notification. Chart reviews will be conducted to ensure documentation of patient notification with the required timeframes.

**Recommendation 11.** We recommended that processes be strengthened to ensure that pre-sedation assessment documentation is completed within the required timeframe and includes all required elements.

Concur

Target date for completion: August 1, 2012

The pre-sedation template will be up-dated to include the required assessment elements. Providers will be trained regarding the required pre-sedation timeframes and elements. Records will be monitored to ensure that all required elements are present and that the required timeframes are met.

**Recommendation 12.** We recommended that processes be strengthened to ensure that checklists are used for all timeouts.

Concur

Target date for completion: February 29, 2012

Laminated checklists have been placed in each sedation room. Training will be provided for nurses and providers on appropriate use of checklists. Observations will be conducted to ensure that the checklist is used.

**Recommendation 13.** We recommended that processes be strengthened to ensure that clinicians screen patients for pneumococcal vaccinations upon admission and at clinic visits.

Concur

Target date for completion: May 31, 2012

Education will be provided to nursing and medical staff regarding their roles and responsibilities in screening patients for pneumococcal vaccinations upon admission and at clinic visits. Chart reviews will be conducted to ensure that screening is conducted upon admission and at clinic visits.

**Recommendation 14.** We recommended that processes be strengthened to ensure that clinicians administer pneumococcal vaccinations when indicated.

Concur

Target date for completion: May 31, 2012

Education will be provided to nursing and medical staff regarding their roles and responsibilities for administering pneumococcal vaccinations. Chart reviews will be conducted to ensure pneumococcal vaccinations are administered when indicated.

**Recommendation 15.** We recommended that processes be strengthened to ensure that clinicians document all required vaccination administration elements and that compliance is monitored.

Concur

Target date for completion: May 31, 2012

The vaccination clinical reminders will be revised to ensure that all required vaccination administration elements are included. Chart reviews will be conducted to ensure that documentation includes all required vaccination administration elements.

**Recommendation 16.** We recommended that processes be strengthened to ensure that patients with positive TBI screening results receive a comprehensive evaluation as outlined in VHA policy.

Concur

Target date for completion: April 30, 2012

A process will be developed to ensure patients with positive TBI screening results receive comprehensive evaluations, as outlined in VHA policy. Additionally, an "Exception Plan" will be submitted to the Chief Medical Officer, VA Northwest Network

VISN 20, requesting approval for evaluations to be completed by trained providers at VA Roseburg.

**Recommendation 17.** We recommended that pharmacists consistently perform and document CLC monthly medication reviews.

Concur

Target date for completion: March 31, 2012

The Chief Pharmacist developed a Task Minder to track the CLC Residents, and the date on which the monthly review is due. Monitoring will be conducted to ensure CLC medication reviews are documented.

# OIG Contact and Staff Acknowledgments

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|---|---|
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