Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 11-04569-141

Combined Assessment Program Review of the VA Puget Sound Health Care System Seattle, Washington

April 3, 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

ACLS	Advanced Cardiac Life Support
BLS	Basic Life Support
CAP	Combined Assessment Program
CLC	community living center
COC	coordination of care
CRC	colorectal cancer
EOC	environment of care
facility	VA Puget Sound Health Care System
FPPE	Focused Professional Practice Evaluation
FY	fiscal year
IUSS	immediate-use steam sterilization
MH RRTP	Mental Health Residential Rehabilitation Treatment Program
MM	medication management
MRI	magnetic resonance imaging
MS	moderate sedation
OIG	Office of Inspector General
PRRC	Psychosocial Rehabilitation and Recovery Center
QM	quality management
SPS	Sterile Processing and Surgical Services
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

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Executive Summary: Combined Assessment Program Review of the VA Puget Sound Health Care System, Seattle, WA

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 January 23, 2012.

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

- Polytrauma
- Psychosocial Rehabilitation and Recovery Centers

The facility's reported accomplishment was the reduction of immediate-use steam sterilization.

Recommendations: We made recommendations in the following six activities:

Quality Management: Ensure completed corrective actions are reported to the Peer Review Committee. Initiate Focused Professional Practice Evaluations for newly hired providers. Ensure resuscitation episodes are reviewed by a multidisciplinary group. Fully implement medical record review processes. Monitor the copy and paste functions quarterly.

Colorectal Cancer Screening: Ensure patients receive diagnostic testing. Notify patients of positive screening test, diagnostic test, and biopsy results within the required timeframe. Require that clinicians document a follow-up plan or that no follow-up is indicated.

Moderate Sedation: Require pre-sedation assessment documentation to include all required elements. Ensure staff is knowledgeable about and implements and documents all required moderate sedation elements. Ensure all required procedural documentation is included in the medical record.

Environment of Care: Secure soiled utility rooms from public access. Perform daily functionality checks on community living center elopement prevention systems. Conduct and document weekly contraband inspections.

Medication Management: Ensure clinicians screen patients for tetanus vaccinations and document all required vaccination administration elements.

Coordination of Care: Ensure care hand-off communication processes adhere to local policy.

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.

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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:

- COC
- CRC Screening
- EOC
- MM
- MS
- 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 January 23, 2012, 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 Puget Sound Health Care System, Seattle, Washington,* Report No. 10-00465-168, June 9, 2010). The facility had corrected all findings. (See Appendix B for further details.)

During this review, we also presented crime awareness briefings for 250 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 995 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 Accomplishment

IUSS

The reduction of IUSS is a national issue faced by SPS departments throughout VHA. In response, the facility established a team that identified IUSS-related equipment issues and solutions, educated facility staff, and implemented processes to monitor and document use of sterilizers. The efforts of this team resulted in a decrease from 117 IUSSs per month in July 2008 to no IUSSs in December 2011.

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.
X	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.
X	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 ACLS 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.
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.

Peer Review. VHA requires that the Peer Review Committee receive written notification upon completion of corrective actions.[1] We reviewed meeting minutes for the period January 2011–December 2011 and identified 11 corrective actions that should have been completed. There was no evidence that seven of these completed corrective actions were reported to the committee.

FPPEs. VHA requires that FPPEs be initiated for all newly hired licensed independent practitioners.[2] We reviewed the profiles of 10 newly hired licensed independent practitioners and found that FPPEs had not been initiated for 4 of the providers.

Resuscitation. VHA requires that a multidisciplinary review of each resuscitation event take place in order to determine whether all standards of care were met and whether local policies were followed.[3] We found that an individual clinician rather than a multidisciplinary group had been reviewing each resuscitation episode.

Medical Record Review. VHA requires facilities to have a medical record committee or an equivalent to provide oversight and coordination of medical record reviews, including quarterly monitoring of the copy and paste functions.[4] The facility recently established a Medical Record Review Workgroup to specifically track and analyze medical record related information. We found that although the facility began quarterly monitoring of the copy and paste functions in May 2011, they had previously tracked this annually.

Recommendations

1. We recommended that processes be strengthened to ensure that the Peer Review Committee receives written notification when corrective actions are completed and that completion is documented in committee minutes.

2. We recommended that processes be strengthened to ensure that FPPEs are consistently initiated for all newly hired licensed independent practitioners.

[1] VHA Directive 2010-025, *Peer Review for Quality Management*, June 3, 2010.
[2] VHA Handbook 1100.19, *Credentialing and Privileging*, November 14, 2008.
[3] VHA Directive 2008-063, *Oversight and Monitoring of Cardiopulmonary Resuscitative Events and Facility Cardiopulmonary Resuscitation Committees,* October 17, 2008.
[4] VHA Handbook 1907.01, *Health Information Management and Health Records*, August 25, 2006.

3. We recommended that processes be strengthened to ensure that a multidisciplinary group reviews all resuscitation episodes.

4. We recommended that the facility fully implement their newly established medical record review processes to ensure coordination and oversight of medical record reviews and that the facility continue to monitor the copy and paste functions quarterly.

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 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.[5] Five 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.[6] Five 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.[7] Seven of the 12 patients who received diagnostic testing did not receive that testing 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.[8] Three of the 12 patients

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

who received diagnostic testing did not have documented evidence of timely notification in their medical records.

Biopsy Result Notification. VHA requires that patients who have a biopsy receive notification within 14 days of the date the biopsy results were confirmed and that clinicians document notification.[9] Eight patients had biopsies. We did not find documented evidence of timely notification in four records.

Recommendations

5. 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.

6. 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.

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

8. 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.

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

[9] VHA Directive 2007-004.

MS

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

We reviewed relevant documents, 11 medical records, and 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.
X	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 MS will be used.[10] Six patients' medical records did not include all the required elements of the history and physical and/or pre-sedation assessment, such as a review of substance use or abuse and an airway assessment.

Timeouts. VHA requires that a timeout occur immediately prior to the start of the procedure[11] and that patients be re-evaluated by the provider immediately before administration of MS.[12] The facility used two different Procedural Sedation Flow Sheets and documentation processes. Staff and administrative interviews demonstrated that expectations for the timing and documentation of the MS process differed. Therefore, we were unable to validate the timing of the required elements of the MS process in seven patients' medical records.

Procedural Documentation. Local policy requires that documentation of intra-procedure and post-procedure monitoring and appropriate discharge documentation be included in patients' medical records. Two patients' medical records did not contain this documentation.

[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.
[12] VHA Directive 2006-023.

Recommendations

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

11. We recommended that processes be strengthened to ensure staff is knowledgeable about and consistently implements and documents all required elements of the MS process.

12. We recommended that processes be strengthened to ensure that all required procedural documentation is included in the medical record.

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 domiciliary's combined Substance Abuse and Post-Traumatic Stress Disorder Residential Rehabilitation Treatment Program complied with selected MH RRTP requirements.

At the Seattle division, we inspected the locked inpatient mental health, medical and surgical inpatient, spinal cord injury, and cardiac care units; the CLC; the emergency department; and the dental, ophthalmology, and primary care clinics. At the American Lake division, we inspected the primary care, gastrointestinal, and urgent care clinics; the CLC; the locked dementia unit; and the domiciliary's combined Substance Abuse and Post-Traumatic Stress Disorder Residential Rehabilitation Treatment Program. 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.
	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 MM, contraband detection, and inspections.
X	MH RRTP inspections were conducted, included all required elements, and were documented.
	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.

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 three units at the Seattle division. Soiled utility rooms contain potentially dangerous items that should be restricted from public access.

VHA requires that functionality checks of elopement prevention systems in CLCs be conducted and documented at least every 24 hours.[13] Daily functionality checks were not conducted on the CLC elopement prevention systems at the Seattle and American Lake divisions.

MH RRTP Inspections. VHA requires facilities to conduct and document weekly MH RRTP contraband detection inspections for a minimum of 10 percent of resident rooms, lockers, and drawers.[14] We found that weekly MH RRTP contraband detection inspections did not meet the 10 percent requirement.

Recommendations

13. We recommended that processes be strengthened to ensure that soiled utility rooms are secured from public access.

14. We recommended that processes be strengthened to ensure that daily functionality checks are performed on CLC elopement prevention systems and documented.

15. We recommended that processes be strengthened to ensure that MH RRTP weekly inspections for contraband detection are conducted and documented in at least 10 percent of required areas.

[13] VHA Directive 2010-052, *Management of Wandering and Missing Patients*, December 3, 2010.
[14] VHA Handbook 1162.02, *Mental Health Residential Rehabilitation Treatment Program (MH RRTP)*, December 22, 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 30 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.
	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. Twelve of 20 records lacked documentation of vaccination screening for tetanus.

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 the vaccine manufacturer in six (20 percent) records.

Recommendations

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

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

COC

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

We reviewed 18 heart failure patients' medical records and relevant facility policies, and we interviewed employees. The area marked as noncompliant in the table below needed improvement. Details regarding the finding follow the table.

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.
X	The facility complied with any additional elements required by local policy.

Care Hand-Off Communication. Local policy requires that at the time of discharge from inpatient care, each patient will have documented in his or her medical record the name of a clinical provider responsible for follow-up care. The identified clinical provider will be notified of the discharge date and follow-up expectations by the discharging provider. Seven medical records did not contain all required elements of hand-off communication.

Recommendation

18. We recommended that care hand-off communication processes be strengthened to ensure adherence to local policy.

Review Activities Without Recommendations

Polytrauma

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

We reviewed relevant documents, 10 medical records of patients with positive traumatic brain injury results, and training records, and we interviewed key staff. The table below details the areas reviewed. The facility generally met requirements. We made no recommendations.

Noncompliant	Areas Reviewed
	Providers communicated the results of the traumatic brain injury screening to patients and referred patients for comprehensive evaluations within the required timeframe.
	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-Traumatic Brain Injury System of Care facilities provided an appropriate care environment.
	The facility complied with any additional elements required by local policy.

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 Mental Health 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 PRRCs at the Seattle and American Lake divisions, and interviewed employees. The table below details the areas reviewed. The facility generally met requirements. We made no recommendations.

Noncompliant	Areas Reviewed
	A PRRC was implemented and was considered fully designated by the Office of Mental Health 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.
	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.

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 22–29, for the full text of the Directors' comments.) We will follow up on the planned actions until they are completed.

Facility Profile[15]		
Type of Organization	Tertiary care medical center	
Complexity Level	1a	
VISN	20	
Community Based Outpatient Clinics	Bremerton, WA Mount Vernon, WA Port Angeles, WA Chehalis, WA Bellevue, WA Federal Way, WA Seattle, WA	
Veteran Population in Catchment Area	447,347	
Type and Number of Total Operating Beds: • **Hospital, including Psychosocial Residential Rehabilitation Treatment Program**	255	
• **CLC/Nursing Home Care Unit**	121	
• **Other**	Spinal cord injury – 34 Domiciliary – 60 Blind rehabilitation – 11	
Medical School Affiliation	University of Washington	
• **Number of Residents**	698	
	Prior FY (2011)	**Prior FY (2010)**
Resources (in millions):		
• **Total Medical Care Budget**	$635.7	$568.4
• **Medical Care Expenditures**	$635.7	$568.4
Total Medical Care Full-Time Employee Equivalents	3,200.21	2,990.76
Workload:		
• **Number of Station Level Unique Patients**	87,465	65,439
• **Inpatient Days of Care:**		
o **Acute Care**	57,947	30,755
o **CLC/Nursing Home Care Unit**	32,551	16,434
Hospital Discharges	8,301	4,488
Total Average Daily Census (including all bed types)	313.9	323.5
Cumulative Occupancy Rate (in percent)	70.2	69.53
Outpatient Visits	903,522	418,384

[15] All data provided by facility management.

Follow-Up on Previous Recommendations		
Recommendations	**Current Status of Corrective Actions Taken**	**Repeat Recommendation? Y/N**
QM		
1. Ensure that an effective process is developed to monitor BLS and ACLS certification.	Staff required to have ACLS/BLS certification are designated in the Talent Management System using a tracking mechanism established by the Center for Education and Development. Staff members and supervisors are sent a reminder prior to the expiration of ACLS/BLS. Each service line with staff members requiring ACLS/BLS track staff training status through monthly or more frequent reviews.	N
MRI Safety		
2. Require that MRI safety questionnaires include all required data and are reviewed and documented by MRI personnel.	Employees must complete a questionnaire prior to being allowed in the MRI room. Employee health and an MRI technologist review the questionnaires to ensure standards are met. Employee health creates a quarterly spreadsheet of all employees cleared for MRI. Following an initial MRI safety screening completed by the ordering provider, patients fill out a questionnaire that is reviewed by an MRI technologist to ensure that all data is accurate and that no safety issues are present. Following the MRI, the questionnaire is scanned into the electronic medical record. The diagnostic imaging quality consultant performs a quality check of 30 records. These checks have demonstrated compliance with appropriate screening and documentation.	N
Reusable Medical Equipment		
3. Require that flash sterilization is used in the operating room only in cases of emergency and that a process for ongoing monitoring of flash sterilization is implemented.	A SharePoint site was established to track IUSS. Data from the site is reviewed and documented daily with the reason IUSS was required. In addition, alternate devices were purchased after identification of recurring items requiring IUSS, resulting in a continued reduction in IUSS. SPS reports to leadership daily on	N

Recommendations	Current Status of Corrective Actions Taken	Repeat Recommendation? Y/N
	the status of IUSS, and an agreement between the operating room and SPS was put into place so IUSS will only occur after consulting with a SPS supervisor. There has been a reduction of IUSS. The current average is 3–5 per month compared to 80–90 per month in March 2009.	
4. Require that all reusable medical equipment competencies are documented and evaluated annually.	All SPS competencies for reusable medical equipment are documented and evaluated yearly. A competency grid was developed and posted in each work location to enable staff to identify their competency. Supervisors have a monthly reminder that notifies them when competencies are going to expire.	N
COC		
5. Require staff to complete inter-facility transfer documentation, and implement processes to monitor and evaluate transfers.	A facility action team was formed to discuss ways to improve compliance with inter-facility transfer documentation. The computer application coordinator updated VistA to include the inter-facility transfer document in the notes section of the medical record and a pop-up window in the orders section. This window comes up when a provider opens an inter-facility transfer order and requires completion of the inter-facility transfer form prior to finalizing the order. Accreditation readiness will continue tracking inter-facility transfers daily until 4 months of data show meeting/exceeding a 95-percent threshold. Random monthly tracking will continue for 4 months to ensure the new process is hard-wired into the system.	N

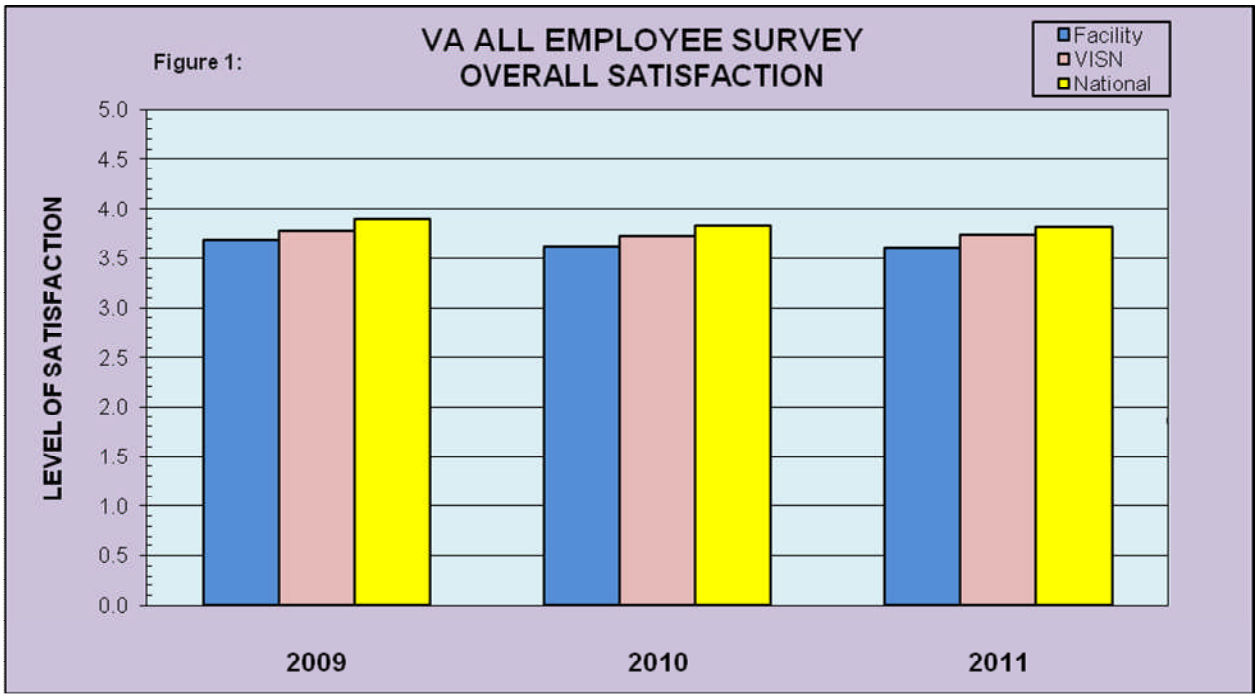
VHA Satisfaction Surveys

VHA has identified patient and employee satisfaction scores as significant indicators of facility performance. Patients are surveyed monthly. Table 1 below shows facility, VISN, and VHA overall inpatient and outpatient satisfaction scores and targets for FY 2011.

Table 1

	FY 2011 Inpatient Scores		FY 2011 Outpatient Scores			
	Inpatient Score Quarters 1–2	Inpatient Score Quarters 3–4	Outpatient Score Quarter 1	Outpatient Score Quarter 2	Outpatient Score Quarter 3	Outpatient Score Quarter 4
Facility	55.0	56.8	43.9	42.6	45.6	45.6
VISN	61.6	65.5	49.4	47.6	46.4	49.8
VHA	63.9	64.1	55.9	55.3	54.2	54.5

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.[16] 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.[17]

Table 2

	Mortality			Readmission		
	Heart Attack	Congestive Heart Failure	Pneumonia	Heart Attack	Congestive Heart Failure	Pneumonia
Facility	17.1	10.8	9.6	20.9	23.5	18.7
U.S. National	15.9	11.3	11.9	19.8	24.8	18.4

[16] 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 heart failure 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.

[17] 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: March 21, 2012

From: Network Director, VISN 20 (10N20)

Subject: **CAP Review of the VA Puget Sound Health Care System, Seattle, WA**

To: Director, Seattle Office of Healthcare Inspections (54SE)

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

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 Puget Sound Health Care System, Seattle, Washington.

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 Nancy Benton, Quality Management Officer, VISN 20 at (360) 619-5949.

(original signed by:)
Susan Pendergrass, DrPH

Facility Director Comments

Department of Veterans Affairs **Memorandum**

Date: March 20, 2012

From: Director, VA Puget Sound Health Care System (663/00)

Subject: **CAP Review of the VA Puget Sound Health Care System, Seattle, WA**

To: Director, Northwest Network (10N20)

1. The status report on the follow-up to the findings from the Combined Assessment Program Review of the VA Puget Sound Health Care System is attached. It includes the facility concurrences and responses to each of the findings from the review.

2. If you have additional questions or need further information, please contact Ward Cassels, Accreditation Readiness Coordinator at (206) 768-5241 or ward.cassels@va.gov.

(original signed by:)
DAVID A. ELIZALDE
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 the Peer Review Committee receives written notification when corrective actions are completed and that completion is documented in committee minutes.

Concur

Target date for completion: 3/30/2012

The Peer Review Committee will receive a written report with all pending and newly closed items.

Peer Review Committee Minutes will incorporate documentation of corrective action completions in the minutes

Recommendation 2. We recommended that processes be strengthened to ensure that FPPEs are consistently initiated for all newly hired licensed independent practitioners.

Concur

Target date for completion: 4/30/2012

Credentialing and Privileging Office monitors the Focused Provider Practice Evaluations (FPPEs) of newly hired licensed independent practitioners. To strengthen the process, alert reminders will be sent to the Clinical Executive Credentialing and Privileging Board members 30 days in advance of the due date. A FPPE spreadsheet is available and shared with the service line leaders to use in tracking due dates. Notification will also be included on the Clinical Executive Credentialing and Privileging Board agenda.

Recommendation 3. We recommended that processes be strengthened to ensure that a multidisciplinary group reviews all resuscitation episodes.

Concur

Target date for completion: 4/5/2012

A multidisciplinary team (Respiratory Therapy, Nursing and a Physician) will review all resuscitation episodes. Reviews will be presented to Emergency Care Committee on a monthly basis.

Recommendation 4. We recommended that the facility fully implement their newly established medical record review processes to ensure coordination and oversight of

medical record reviews and that the facility continue to monitor the copy and paste functions quarterly.

Concur

Target date for completion: 2/21/2012

This action is completed. The medical record review process has been in place since May 2011. The review process is fully implemented, and monitoring is ongoing to ensure coordination and oversight of medical record reviews. The Facility continues to monitor the copy and paste function quarterly. The copy and paste function/reviews will continue to be presented quarterly to the Clinical Executive Board (CEB).

Recommendation 5. 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: 4/30/2012

Our Gastrointestinal (GI) Program and General Medicine Service developed and implemented a process in December 2011 to ensure that patients are notified of positive colorectal cancer (CRC) screening test results within the required timeframe and that the clinicians document the notification. On a weekly basis, all FOBT positive reports are monitored and compared to the GI Consult Report and GI Fee List to assure that a consult to GI has been generated. If a consult has not been generated the Primary Care Provider (PCP) or ordering provider is contacted for the appropriate action.

Recommendation 6. 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: 4/30/2012

The above recommendation refers to Recommendation 5. Currently, a team monitors the computerized patient record system (CPRS) for positive results and notifies the provider to contact patients within the policy time frame. The team also ensures that the responsible clinicians either develop follow-up plans or document that no follow-up is indicated within the required timeframe.

Recommendation 7. 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: 4/30/2012

The GI program will prioritize procedures in-house for Veterans with fecal occult blood test (FOBT) positive results to assure compliance with the 60 day requirement.

For those Veterans where fee for service is necessary, they will receive priority scheduling and the GI program administrative staff will monitor progress to assure compliance with the 60 day requirement.

Recommendation 8. 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: 2/2/2012

This action is completed. Veterans are given a copy of their colonoscopy report at the time of discharge from the endoscopy unit. In the event that the report is not yet available, it is mailed to the Veteran upon completion the next business day. Notification is documented in CPRS.

Recommendation 9. 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: 4/30/2012

Processes are in place to notify Veterans of their biopsy results. The current process involves compiling pathology results by the GI administrative staff and having the GI Fellow send letters to the patients with their results and documenting this in the GI endoscopy software package as well as CPRS.

Recommendation 10. We recommended that processes be strengthened to ensure that pre-sedation assessment documentation includes all required elements.

Concur

Target date for completion: 5/30/2012

The MD Pre-Sedation Assessment template will be revised and in place by 4/30/12. The templates will contain all required elements of VHA Directive 2006-023. Education of providers about the use of the appropriate template will occur prior to 5/30/12.

Recommendation 11. We recommended that processes be strengthened to ensure staff is knowledgeable about and consistently implements and documents all required elements of the MS process.

Concur

Target date for completion: 5/30/2012

To assure consistency in process and documentation, the moderate sedation (MS) procedural flow sheets were standardized between both divisions in November 2011. Staff involved in the moderate sedation process were educated on use of the new flow sheet prior to implementation.

Recommendation 12. We recommended that processes be strengthened to ensure that all required procedural documentation is included in the medical record.

Concur

Target date for completion: 3/30/2012

Two of eleven patient's medical records did not contain the paper copy of the flow sheet that includes the intraprocedure and post-procedure monitoring and discharge documentation. To strengthen the process, a cover sheet will be developed by the procedural areas in conjunction with medical records to assure that information that is sent from procedural areas to medical records for scanning has contact information in case any items are illegible or questions arise.

Recommendation 13. We recommended that processes be strengthened to ensure that soiled utility rooms are secured from public access.

Concur

Target date for completion: 6/1/2012

A facility team, consisting of Facilities Management, Safety, Infection Control, Patient Safety and the Unit Managers will conduct a risk assessment of all unsecured soiled utility rooms to determine the appropriate method of securing each room from public access.

Based on this risk assessment, utility rooms requiring locking mechanisms will be evaluated for the appropriate type of locking mechanism and locks will be installed on the utility room doors.

Recommendation 14. We recommended that processes be strengthened to ensure that daily functionality checks are performed on CLC elopement prevention systems and documented.

Concur

Target date for completion: 3/30/2012

A diagnostic checklist was developed and will be completed daily for the functionality diagnostic check on the Community Living Center (CLC) elopement system.

Recommendation 15. We recommended that processes be strengthened to ensure that MH RRTP weekly inspections for contraband detection are conducted and documented in at least 10 percent of required areas.

Concur

Target date for completion: 1/30/2012

This process has been implemented. In the Mental Health Residential Treatment and Rehabilitation (MH RRTP) program a process was designed to ensure at least 10% of the residents are subject to contraband check on a weekly basis. This process was implemented but did not have documentation of a 12 months track record of inspections.

Recommendation 16. We recommended that processes be strengthened to ensure that clinicians screen patients for tetanus vaccinations upon admission and at clinic visits.

Concur

Target date for completion: 3/9/2012

This process has been implemented. The admission order set for the CLC now contains orders for Tetanus vaccine effective 2/1/2012.

A clinical reminder for Tetanus has been developed for clinic visits. The clinical reminder has been piloted and will be in place by 3/9/2012.

Recommendation 17. 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: 3/30/2012

All vaccine documentation templates have been reviewed and all required elements are included. Data will be pulled for all tetanus vaccines given between 2/15/12–3/14/12

and assessed for the required vaccination administration elements. If compliance is greater than 90% monitoring will move to spot checks.

Recommendation 18. We recommended that care hand-off communication processes be strengthened to ensure adherence to local policy.

Concur

Target date for completion: 6/1/2012

A review of facility policy PE-01, *Admission to and Discharge from VAPSHCS* found that the contents of the policy were in duplication of alternate facility policies. Policy PE-01 was accordingly rescinded.

A random review of 10 records per month will be completed to verify that handoff communication is accomplished in accordance with facility policy. This review will continue until 90% compliance is achieved for three consecutive months.

OIG Contact and Staff Acknowledgments

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