Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 12-02189-14

Combined Assessment Program Review of the VA Long Beach Healthcare System Long Beach, California

October 17, 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
COC	coordination of care
CRC	colorectal cancer
EHR	electronic health record
EOC	environment of care
facility	VA Long Beach Healthcare System
FY	fiscal year
HF	heart failure
MH	mental health
MM	medication management
OIG	Office of Inspector General
PI	performance improvement
POCT	point-of-care testing
QM	quality management
SCI	spinal cord injury
TBI	traumatic brain injury
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

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Executive Summary: Combined Assessment Program Review of the VA Long Beach Healthcare System, Long Beach, CA

Review Purpose: The purpose was to evaluate selected activities, focusing on patient care administration and quality management, and to provide crime awareness training. We conducted the review the week of July 30, 2012.

Review Results: The review covered 12 activities. We made no recommendations in the following activities:

- Medication Management
- Nurse Staffing
- Quality Management

The facility's reported accomplishment was the expedited placement confirmation of peripherally inserted central catheter lines.

Recommendations: We made recommendations in the following nine activities:

Moderate Sedation: Include all required elements in pre-sedation assessment documentation.

Point-of-Care Testing: Complete the actions required in response to critical test results.

Colorectal Cancer Screening: Notify patients of positive screening test results, develop follow-up plans or document that no follow-up is indicated, and ensure patients receive diagnostic testing within the required timeframe.

Polytrauma: Ensure that patients with positive traumatic brain injury screening results receive a comprehensive evaluation as outlined in Veterans Health Administration policy and that interdisciplinary treatment plans are developed for polytrauma outpatients.

Mental Health Treatment Continuity: Ensure all discharged mental health patients receive follow-up within the specified timeframes.

Coordination of Care: Ensure discharge instructions address diet and the initial follow-up appointment.

Environment of Care: Conduct safety inspections on all ceiling lifts in the Spinal Cord Injury Center, and ensure all required participants attend environment of care rounds.

Follow-Up on Coordination of Care Issue: Report results of inter-facility transfer tracking and trending, and incorporate education on inter-facility transfers into new resident orientation.

Follow-Up on Environment of Care Issues: Correct deficiencies within the required timeframe, and correct identified general cleanliness and maintenance issues.

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 12 activities:

- COC
- CRC Screening
- EOC
- Follow-up on COC Issue
- Follow-up on EOC Issues
- MH Treatment Continuity
- MM
- Moderate Sedation
- Nurse Staffing
- POCT
- 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 2011 and FY 2012 through July 30, 2012, and was done in accordance with OIG standard operating procedures for CAP reviews. We also asked the facility to provide us with their current status on the recommendations we made in our previous CAP report (*Combined Assessment Program Review of the VA Long Beach Healthcare System, Long Beach, California,* Report No. 10-02382-254, September 22, 2010). The facility had repeat findings in COC and EOC.

During this review, we presented crime awareness briefings for 660 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 558 responded. We shared survey results 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

Expedited Placement Confirmation of Peripherally Inserted Central Catheter Lines

In June 2011, the facility adopted the Sapiens technology, which uses electrocardiogram verification for catheter tip confirmation during placement. This technology has reduced the wait time for peripherally inserted central catheter line infusion therapy from the traditional 4 to 6 hours to immediate use upon insertion. The cost savings includes the avoidance of approximately 400 chest x-rays per year at an average cost of $138 per x-ray. In addition, this new technology enhances the facility's ability to render care without delay to patients requiring immediate and reliable central venous access for medical treatment, intravenous infusion, blood product transfusion, and total parenteral nutrition. Furthermore, it facilitates patient flow from the acute care setting to transitional care for long-term antibiotic therapy.

Results
Review Activities With Recommendations

Moderate Sedation

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

We reviewed relevant documents, 10 EHRs, and 13 training/competency records, and we interviewed key employees. The area marked as noncompliant in the table below needed improvement. Details regarding the finding 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.
	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.[1] Three patients' EHRs did not include all required elements of the pre-sedation assessment, such as alcohol and substance use.

Recommendation

1. We recommended that processes be strengthened to ensure that pre-sedation assessment documentation includes all required elements and that compliance be monitored.

[1] VHA Directive 2006-023, *Moderate Sedation by Non-Anesthesia Providers*, May 1, 2006.

POCT

The purpose of this review was to evaluate whether the facility's inpatient blood glucose POCT program complied with applicable laboratory regulatory standards and quality testing practices as required by VA, the College of American Pathologists, and The Joint Commission.

We reviewed the EHRs of 30 patients who had glucose testing, 12 employee training and competency records, and relevant documents. We also performed physical inspections of four patient care areas where glucose POCT was performed, and we interviewed key employees involved in POCT management. The area marked as noncompliant in the table below needed improvement. Details regarding the finding follow the table.

Noncompliant	Areas Reviewed
	The facility had a current policy delineating testing requirements and oversight responsibility by the Chief of Pathology and Laboratory Medicine Service.
	Procedure manuals were readily available to staff.
	Employees received training prior to being authorized to perform glucose testing.
	Employees who performed glucose testing had ongoing competency assessment at the required intervals.
	Test results were documented in the EHR.
	Facility policy included follow-up actions required in response to critical test results.
X	Critical test results were appropriately managed.
	Testing reagents and supplies were current and stored according to manufacturers' recommendations.
	Quality control was performed according to the manufacturer's recommendations.
	Routine glucometer cleaning and maintenance was performed according to the manufacturer's recommendations.
	The facility complied with any additional elements required by local policy.

Test Results Management. When glucose values are determined to be critical, the facility requires the employee performing the test to repeat the finger stick with another nurse within 15 minutes and notify the physician immediately. Of the 10 patients who had critical test results, 5 EHRs did not contain evidence of a repeat glucose test, and 2 EHRs did not contain evidence of physician notification.

Recommendation

2. We recommended that processes be strengthened to ensure that staff complete the actions required in response to critical test results and document the actions taken.

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 the facility's CRC screening.

We reviewed the EHRs of 20 patients who had positive CRC screening tests and 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.
	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.[2] Ten patients' EHRs did not contain documented evidence of timely notification, and two patients' EHRs did not contain any documented evidence of 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.[3] Six patients' EHRs did not have a documented follow-up plan within the required timeframe, and two patients' EHRs did have any documented evidence of a follow-up plan.

Diagnostic Testing Timeliness. VHA requires that patients receive diagnostic testing within 60 days of positive CRC screening test results unless contraindicated.[4] Five of the 11 patients who received diagnostic testing did not receive the testing within 60 days. Two of these patients preferred testing dates beyond 60 days, and one patient cancelled the scheduled appointment. For the remaining two patients, the facility did not schedule and complete the diagnostic testing within the required timeframe.

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

Recommendations

3. 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.

4. 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.

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

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 EHRs of patients with positive TBI results, 10 EHRs of patients receiving TBI outpatient services, and 10 training records, and we interviewed key employees. The areas marked as noncompliant in the table below needed improvement. Details regarding the findings 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.
X	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.

Timely Evaluation. VHA requires that patients with positive TBI screening results have a comprehensive TBI evaluation following the positive screening.[5] Two of the 10 EHRs of patients with positive TBI results did not contain evidence that a comprehensive evaluation was completed.

Outpatient Treatment Plan. VHA requires that polytrauma outpatients who need interdisciplinary care have a specific interdisciplinary treatment plan developed.[6] None of the 10 EHRs of patients receiving TBI outpatient services had the required treatment plan.

[5] 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.
[6] VHA Handbook 1172.04, *Physical Medicine and Rehabilitation Individualized Rehabilitation and Community Reintegration Care Plan,* May 3, 2010.

Recommendations

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

7. We recommended that processes be strengthened to ensure that outpatients who need interdisciplinary care have treatment plans developed.

MH Treatment Continuity

The purpose of this review was to evaluate the facility's compliance with VHA requirements related to MH patients' transition from the inpatient to outpatient setting, including follow-up after discharge.

We interviewed key employees and reviewed relevant documents and the EHRs of 30 patients discharged from acute MH (including 10 patients deemed at high risk for suicide). The area marked as noncompliant in the table below needed improvement. Details regarding the finding follow the table.

Noncompliant	Areas Reviewed
X	After discharge from a MH hospitalization, patients received outpatient MH follow-up in accordance with VHA policy.
	Follow-up MH appointments were made prior to hospital discharge.
	Outpatient MH services were offered at least one evening per week.
	Attempts to contact patients who failed to appear for scheduled MH appointments were initiated and documented.
	The facility complied with any additional elements required by local policy.

Outpatient Follow-Up. VHA requires that all patients discharged from inpatient MH receive outpatient follow-up from a MH provider within 7 days of discharge and that if this contact is by telephone, an in-person or telemental health evaluation must occur within 14 days of discharge.[7] Seven of the 20 patients who were not on the high risk for suicide list did not receive outpatient MH follow-up within the specified timeframes. Three patients did not receive any follow-up. Two patients received telephone follow-up within 7 days of discharge but did not receive a face-to-face or telehealth evaluation within 14 days of discharge. Additionally, 2 patients did not receive follow-up within 7 days of discharge but did receive a face-to-face evaluation within 14 days of discharge.

Follow-Up for High Risk for Suicide Patients. VHA requires that patients discharged from inpatient MH who are on the high risk for suicide list be evaluated at least weekly during the first 30 days after discharge.[8] Although documentation shows that MH staff consistently contacted patients to remind them of scheduled appointments, followed up on patients who did not keep scheduled appointments, and rescheduled appointments, 4 of the 10 patients who were on the high risk for suicide list did not receive MH follow-up at the required intervals.

[7] VHA Handbook 1160.01, *Uniform Mental Health Services in VA Medical Centers and Clinics,* September 11, 2008.
[8] Principal Deputy Under Secretary for Health and Deputy Under Secretary for Health for Operations and Management, "Patients at High-Risk for Suicide," Memorandum, April 24, 2008.

Recommendations

8. We recommended that processes be strengthened to ensure that all discharged MH patients who are not on the high risk for suicide list receive follow-up within the specified timeframes and that compliance be monitored.

9. We recommended that all discharged MH patients who are on the high risk for suicide list receive follow-up at the required intervals and that compliance be monitored.

COC

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 24 HF patients' EHRs and relevant documents and interviewed key 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.
X	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.

Discharge Instruction Components. VHA requires that discharge instructions address medications, diet, and the initial follow-up appointment.[9] Four EHRs did not include instructions for diet, and one EHR did not contain documentation regarding the initial follow-up appointment.

Recommendation

10. We recommended that processes be strengthened to ensure that discharge instructions address diet and the initial follow-up appointment.

[9] VHA Handbook 1907.01, *Health Information Management and Health Records,* August 25, 2006.

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.

We inspected 12 inpatient units (three SCI, two medical, two locked MH, two CLC, one surgical, one intensive care, and one blind rehabilitation), the emergency department, and five outpatient clinics (one dental, one SCI, one buprenorphine, and two primary care). Additionally, we reviewed relevant documents and training records, and we interviewed key 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 General EOC
	EOC Committee minutes reflected sufficient detail regarding identified deficiencies, progress toward resolution, and tracking of items to closure.
	Infection prevention risk assessment and committee minutes reflected identification of high-risk areas, analysis of surveillance activities and data, actions taken, and follow-up.
	Patient care areas were clean.
	Fire safety requirements were met.
	Environmental safety requirements were met.
	Infection prevention requirements were met.
	Medication safety and security requirements were met.
	Sensitive patient information was protected, and patient privacy requirements were met.
X	The facility complied with any additional elements required by VHA or local policy.
	Areas Reviewed for Dental EOC
	If lasers were used in the dental clinic, staff who performed or assisted with laser procedures received medical laser safety training, and laser safety requirements were met.
	General infection control practice requirements in the dental clinic were met.
	Dental clinic infection control process requirements were met.
	Dental clinic safety requirements were met.
	The facility complied with any additional elements required by local policy.
	Areas Reviewed for SCI EOC
X	EOC requirements specific to the SCI Center and/or outpatient clinic were met.
	SCI-specific training was provided to staff working in the SCI Center and/or SCI outpatient clinic.
	The facility complied with any additional elements required by local policy.
	Areas Reviewed for MH Residential Rehabilitation Treatment Program
	There was a policy that addressed safe MM, contraband detection, and inspections.
	MH Residential Rehabilitation Treatment Program inspections were conducted, included all required elements, and were documented.
	Actions were initiated when deficiencies were identified in the residential environment.

Noncompliant	Areas Reviewed for MH Residential Rehabilitation Treatment Program (continued)
	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.

SCI Environmental Safety. VHA requires that all ceiling mounted patient lift systems are inspected after installation and that the inspection is documented on the After Installation Checklist.[10] We requested inspection documentation for 10 ceiling lifts in the SCI Center. There was no documentation for any of the ceiling lifts.

EOC Rounds. VHA requires that the Director or Associate Director lead weekly EOC rounds.[11] Managers in nursing, building management, engineering, safety, patient safety, and infection control must be included as well as the Information Security Officer and others, as required. We reviewed EOC rounds documentation and determined that all required participants or their designees did not consistently participate in EOC rounds.

Recommendations

11. We recommended that processes be strengthened to ensure that safety inspections are conducted on all ceiling lifts in the SCI Center and documented.

12. We recommended that processes be strengthened to ensure that all required participants or their designees consistently attend EOC rounds.

[10] VA National Center for Patient Safety, "Ceiling mounted patient lift installations," Patient Safety Alert 10-07, March 22, 2010.
[11] Deputy Under Secretary for Health for Operations and Management, "Environmental Rounds," memorandum, March 5, 2007.

Review Activities with Previous CAP Recommendations

Follow-Up on COC Issue

As a follow-up to a recommendation from our prior CAP review, we reassessed facility compliance with the inter-facility patient transfer process.

Inter-Facility Transfers. VHA requires that inter-facility transfers be monitored and evaluated as part of the QM program.[12] We found that the facility's action plans in response to our previous recommendation were not fully implemented. The facility is tracking and trending all transfers into and out of the facility, and the VA inter-facility transfer form has been implemented in the EHR. However, we did not find documentation that results of tracking and trending of transfers were reported to the Organizational Excellence Board. Additionally, education on inter-facility transfers has not been incorporated into new resident orientation.

Recommendation

13. We recommended that processes be implemented to report results of tracking and trending of inter-facility transfers to the Organizational Excellence Board and to incorporate education on inter-facility transfers into new resident orientation.

Follow-Up on EOC Issues

As a follow-up to recommendations from our prior CAP review, we reassessed facility compliance with EOC deficiency tracking, general cleanliness, and maintenance issues.

EOC Deficiency Tracking. The facility established target rates of 90 percent for 14-day completion of EOC deficiencies or the submission of an action plan for deficiencies not corrected within 14 days. We reviewed the facility's EOC deficiency tracking reports for 3 quarters of FY 2012. The facility did not meet its target of 90 percent completion within 14 days in 2 of the 3 quarters. Additionally, the facility did not meet its target for submitting action plans for deficiencies not corrected within 14 days in any of the 3 quarters.

General Cleanliness and Maintenance Issues. The Joint Commission requires areas used by patients to be clean and well maintained. During our inspection, we found general cleanliness and maintenance issues in 12 out of 18 patient care areas. We found stains and scuff marks on walls, doors, and handrails and multiple areas with chipped or peeling paint. Additionally, we found dirt and debris on floors and along baseboards, dust accumulation on ventilation system covers, and unrepaired or inadequately repaired drywall.

[12] VHA Directive 2007-015, *Inter-Facility Transfer Policy*, May 7, 2007.

Recommendations

14. We recommended that processes be strengthened to ensure that EOC deficiencies are corrected within the required timeframe and that action plans are submitted for deficiencies not corrected within the required timeframe.

15. We recommended that facility managers conduct a comprehensive EOC inspection of the facility and take appropriate actions to correct identified general cleanliness and maintenance issues.

Review Activities Without Recommendations

MM

The purpose of this review was to determine whether the facility complied with selected requirements for opioid dependence treatment, specifically, opioid agonist[13] therapy with methadone and buprenorphine and handling of methadone.

We reviewed 10 EHRs of patients receiving methadone or buprenorphine for evidence of compliance with program requirements. We also reviewed relevant documents, interviewed key employees, and inspected the methadone storage area (if any). The table below details the areas reviewed. The facility generally met requirements. We made no recommendations.

Noncompliant	Areas Reviewed
	Opioid dependence treatment was available to all patients for whom it was indicated and for whom there were no medical contraindications.
	If applicable, clinicians prescribed the appropriate formulation of buprenorphine.
	Clinicians appropriately monitored patients started on methadone or buprenorphine.
	Program compliance was monitored through periodic urine drug screenings.
	Patients participated in expected psychosocial support activities.
	Physicians who prescribed buprenorphine adhered to Drug Enforcement Agency requirements.
	Methadone was properly ordered, stored, and packaged for home use.
	The facility complied with any additional elements required by local policy.

[13] A drug that has affinity for the cellular receptors of another drug and that produces a physiological effect.

Nurse Staffing

The purpose of this review was to determine the extent to which the facility implemented the staffing methodology for nursing personnel and to evaluate nurse staffing on one selected acute care unit.

We reviewed relevant documents and 10 training files and interviewed key employees. Additionally, we reviewed the actual nursing hours per patient day for one acute care unit (8S) for 30 randomly selected days (holidays, weekdays, and weekend days) between October 2011 and March 2012. The table below details the areas reviewed. The facility generally met requirements. We made no recommendations.

Noncompliant	Areas Reviewed
	The unit-based expert panels followed the required processes.
	The facility expert panel followed the required processes.
	Members of the expert panels completed the required training.
	The facility completed the required steps to develop a nurse staffing methodology by the deadline.
	The selected unit's actual nursing hours per patient day met or exceeded the target nursing hours per patient day.
	The facility complied with any additional elements required by local policy.

QM

The purpose of this review was to determine whether facility senior managers actively supported and appropriately responded to QM efforts and whether the facility complied with selected requirements within its QM program.

We interviewed senior managers and key QM employees, and we evaluated meeting minutes, EHRs, and other relevant documents. The table below details the areas reviewed. The facility generally met requirements. We made no recommendations.

Noncompliant	Areas Reviewed
	There was a senior-level committee/group responsible for QM/PI, 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.
	Focused Professional Practice Evaluations for newly hired licensed independent practitioners complied with selected requirements.
	Staff who performed utilization management reviews met requirements and participated in daily interdisciplinary discussions.
	If cases were referred to a physician utilization management advisor for review, recommendations made were documented and followed.
	There was an integrated ethics policy, and an appropriate annual evaluation and staff survey were completed.
	If ethics consultations were initiated, they were completed and appropriately documented.
	There was a cardiopulmonary resuscitation review policy and process that complied with selected requirements.
	Data regarding resuscitation episodes were collected and analyzed, and actions taken to address identified problems were evaluated for effectiveness.
	If Medical Officers of the Day were responsible for responding to resuscitation codes during non-administrative hours, they had current Advanced Cardiac Life Support certification.
	There was an EHR quality review committee, and the review process complied with selected requirements.
	If the evaluation/management coding compliance report contained failures/negative trends, actions taken to address identified problems were evaluated for effectiveness.
	Copy and paste function monitoring complied with selected requirements.
	The patient safety reporting mechanisms and incident analysis complied with policy.
	There was evidence at the senior leadership level that QM, patient safety, and systems redesign were integrated.
	Overall, if significant issues were identified, actions were taken and evaluated for effectiveness.

Noncompliant	Areas Reviewed (continued)
	Overall, there was evidence that senior managers were involved in PI over the past 12 months.
	Overall, the facility had a comprehensive, effective QM/PI program over the past 12 months.
	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 C and D, pages 24–35, for the full text of the Directors' comments. We will follow up on the planned actions until they are completed.

Facility Profile[14]		
Type of Organization	Tertiary care medical center	
Complexity Level	1C	
VISN	22	
Community Based Outpatient Clinics	Santa Ana, CA Anaheim, CA Laguna Hills, CA Whittier/Santa Fe Springs, CA Villages At Cabrillo, CA	
Veteran Population in Catchment Area	370,000	
Type and Number of Total Operating Beds: • **Hospital, including Psychosocial Residential Rehabilitation Treatment Program**	280	
• **CLC/Nursing Home Care Unit**	95	
• **Other**	0	
Medical School Affiliation(s)	University of California Irvine University of California Los Angeles	
• **Number of Residents**	169.5 (including dental)	
	Current FY (through April 2012)	**Prior FY (2011)**
Resources (in millions):		
• **Total Medical Care Budget**	$440.8	$432.3
• **Medical Care Expenditures**	$242.2	$432.2
Total Medical Care Full-Time Employee Equivalents	2,101	2,134
Workload:		
• **Number of Station Level Unique Patients**	40,167	49,539
• **Inpatient Days of Care:**		
o **Acute Care**	34,812	78,971
o **CLC/Nursing Home Care Unit**	14,200	23,322
Hospital Discharges	4,387	6,620
Total Average Daily Census (including all bed types)	160	148
Cumulative Occupancy Rate (in percent)	55.8	54.9
Outpatient Visits	317,697	615,883

[14] All data provided by facility management.

VHA Satisfaction Surveys

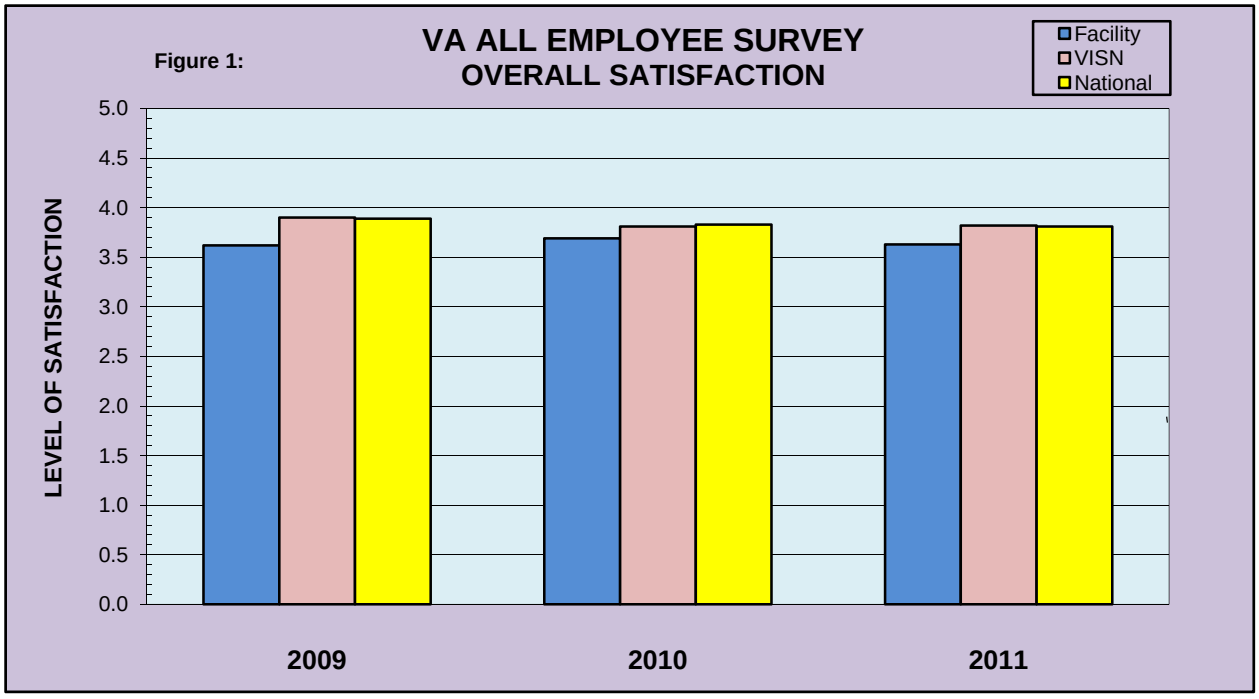
VHA has identified patient and employee satisfaction scores as significant indicators of facility performance. Patients are surveyed monthly. Table 1 below shows facility, VISN, and VHA overall inpatient and outpatient satisfaction scores for quarters 3 and 4 of FY 2011 and quarters 1 and 2 of FY 2012.

Table 1

	Inpatient Scores		Outpatient Scores			
	FY 2011	FY 2012	FY 2011		FY 2012	
	Inpatient Score Quarters 3–4	Inpatient Score Quarters 1–2	Outpatient Score Quarter 3	Outpatient Score Quarter 4	Outpatient Score Quarter 1	Outpatient Score Quarter 2
Facility	67.1	59.2	53.9	50.8	46.9	47.0
VISN	64.5	60.7	49.8	51.7	51.8	52.6
VHA	64.1	63.9	54.2	54.5	55.0	54.7

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.

Figure 1:



Hospital Outcome of Care Measures

Hospital Outcome of Care Measures show what happened after patients with certain conditions received hospital care.[15] 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, 2008, and June 30, 2011.[16]

Table 2

	Mortality			Readmission		
	Heart Attack	Congestive HF	Pneumonia	Heart Attack	Congestive HF	Pneumonia
Facility	14.9	9.5	12.7	20.5	29.2	20.4
U.S. National	15.5	11.6	12.0	19.7	24.7	18.5

[15] 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.

[16] 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: September 26, 2012

From: Director, VA Desert Pacific Healthcare Network (10N22)

Subject: **CAP Review of the VA Long Beach Healthcare System, Long Beach, CA**

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

Director, Management Review Service (VHA 10AR MRS)

1. I concur with the findings and recommendations in the Long Beach CAP Report Draft of the VA Long Beach Healthcare System, Long Beach, CA.

2. If you have any questions regarding our responses and actions to the recommendations in the draft report, please contact me at (562) 826-5963.

(original signed by:)
Stan Johnson, MHA, FACHE

Facility Director Comments

Department of Veterans Affairs **Memorandum**

Date: September 25, 2012

From: Director, VA Long Beach Healthcare System (600/00)

Subject: **CAP Review of the VA Long Beach Healthcare System, Long Beach, CA**

To: Director, VA Desert Pacific Healthcare Network (10N22)

1. I would like to express my sincere appreciation to the Office of the inspector General (OIG), Combined Assessment Program (CAP) review team for their professionalism and excellent feedback provided to our employees during the CAP review conducted July 30–August 3, 2012.

2. I reviewed the recommendations and concur with the findings. Our comments and action plans to the 15 recommendations are attached.

3. If you have questions or require additional information, please contact Nancy Downey, Quality Manager, at (562) 826-5249.

Isabel Duff, MS

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 pre-sedation assessment documentation includes all required elements and that compliance be monitored.

Concur

Target date for completion: December 31, 2012

The Moderate Sedation assessment requirement for screening of alcohol, illicit drugs and smoking was reviewed with all Licensed Independent Practitioners (LIP) providing moderate sedation and clear expectations were established for full compliance. Furthermore, the VA Cardiovascular Assessment, Reporting and Tracking (CART) Program national site manager was contacted on August 1, 2012 to modify the CART template adding verbiage for illicit drugs and alcohol to the application since Cardiac Cath Lab LIPs uses the template to document their Moderate Sedation assessment. The compliance tracking was initiated in August 1, 2012. The data are tracked, trended and reported on a monthly basis to Moderate Sedation subcommittee and Operative and Invasive Committee. This will be monitored for 3 months to assure 95% or greater compliance.

Recommendation 2. We recommended that processes be strengthened to ensure that staff complete the actions required in response to critical test results and document the actions taken.

Concur

Target date for completion: December 31, 2012

The healthcare system has determined that the critical values for Point of Care Testing (POCT) will be <50 and >400. To solidify this standard, the following actions have been implemented. Nursing practice was standardized for responding to Point of Care Testing (POCT) glucose critical values of (<50 and >400) by incorporating these values into the nursing procedure. Nursing will follow the POCT procedure. Critical values of <50 and >400 were installed into the glucometer software. Annual verification and compliance with nursing competencies related to all aspects of the POCT procedure will be conducted. All POCT lab values <50 and >400, will be reported to the Chiefs of Patient Care Services weekly by the designated medical technologist. All charts with critical values will be audited by nursing on weekly basis. The results of these audits will be submitted to the designated QM consultant every 30 days. The designated QM consultant will present monthly, an aggregated report to Nurse Executive Committee (NEC) until 90% compliance is achieved for 3 consecutive months.

Recommendation 3. 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: January 31, 2013

All Primary Care Licensed Independent Providers and staff were educated on the CRC screening requirement of notifying patients of the test result within 14 days of the laboratory receipt date for fecal immunochemical tests (FIT). A CPRS template was developed to document FIT results and is designed to be printed and mailed to patients within the required timeframe. To ensure compliance, a detailed report was developed to review all FIT results. Each PACT Team is provided a weekly report of all FIT results. The staff will review and discuss results in a weekly team huddles. The Primary Care Clinics will complete monthly chart audits of all FIT results to ensure documented evidence of timely notification. The results will be reported quarterly to Clinical Practice Executive Council (CPEC) until 90% or greater compliance has been achieved for 3 consecutive months.

Recommendation 4. 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: January 31, 2013

In addition to the plan of action for recommendation #3, the Primary Care Clinics will complete monthly chart audits of all FIT results to ensure documented evidence of timely follow-up or document evidence that no follow-up is indicated. FPPE will be conducted monthly in the health care groups that perform FIT and results will be reported quarterly to Medical Executive Council (MEC) for 3 consecutive months until 90% or greater compliance has been achieved.

Recommendation 5. 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: January 31, 2013

The staff in GI Lab, including the schedulers, were provided education about the VHA Directive 2007-004-Colorectal Cancer Screening. Scheduling of patients with positive CRC screening test results will be reviewed weekly and if necessary Fee Basis will be utilized to assure that all patients will receive diagnostic testing within the required time frame. An ongoing monitoring for compliance is established. The GI Lab will complete

monthly chart audits to ensure that patients receive diagnostic colonoscopy if indicated within 60 calendar days after positive screening and document if the patient refuses.

The results will be reported quarterly to Clinical Practice Executive Council (CPEC) until 90% or greater compliance has been achieved for 3 consecutive months.

Recommendation 6. 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: October 24, 2012

The comprehensive evaluations of Veterans with positive TBI screening are being completed in a timely manner under the title, PM&R consultation; however, due to a technical issue with the web-based second level evaluation software, some of the "TBI Second Level Evaluations" are not being saved to CPRS on the day of completed data input.

We agree that the process to ensure that Comprehensive Evaluation documentation is completed can be improved. In the event that "TBI Second Level Evaluation" note generated from the national website does not save in CPRS, the physician completing the consultation will ensure that the information is transferred (the PM&R consultation report) into a new note with a "TBI Second Level Evaluation" title. The Case Managers review the charts to insure that the note is input or transferred. If it is not, the Case Managers follow up with IT to alert them to the software failure when it arises.

Information Technology helpdesk and Clinical Application coordinators have been alerted of the observed issues with data not being saved correctly from Web-Based application to CPRS. The Case Managers and Clinical Application coordinators maintain a log of each failure and report the web based failures to the Chief, PM&R.

Case Managers review the chart to ensure that the "TBI Second Level Evaluation" notes are completed and alert the physician in case of a software failure; if there is a software failure the physician is immediately notified to transfer the information to the chart as well as IT and the Clinical Application coordinator.

Audits for Care Plans and the TBI Second Level Evaluation Note are conducted monthly and reported each month at a designated interdisciplinary team meeting as part of a focused chart review and as an additional review process for assurance of compliance. The measure of success is greater than a 90% compliance level that is sustained for four months to insure completion. If the audits demonstrate a measure of success less than the established 90% success rate then the review process will be reconsidered, revised, modified and monitored for an additional four months to insure sustainability.

Recommendation 7. We recommended that processes be strengthened to ensure that outpatients who need interdisciplinary care have treatment plans developed.

Concur

Target date for completion: December 18, 2012

To ensure that initial referrals and assessments are completed, giving the Veterans a chance to work on goal-setting with all the appropriate disciplines sited in the original consultation treatment plan, the team has been completing the interdisciplinary "Reintegration Plan of Care" within 3 months after the Second Level TBI evaluation. As an improvement process, the Interdisciplinary team has agreed to work towards completing the Reintegration Plan of Care development and documentation within 30 days following completion of the Second Level TBI evaluation (PM&R consultation appointment).

Case Managers audit and review the charts for compliance with the Plan of Care 30 day target and report at the monthly team meeting. A measure of success of 90% has been agreed to by the team. The Case Managers review the charts for the 30 day compliance rate for a 4 month period of sustainability. If a 90% measure of success is not reached during that time, then the process is reviewed and revised and monitored for an additional 4 months.

Recommendation 8. We recommended that processes be strengthened to ensure that all discharged MH patients who are not on the high risk for suicide list receive follow-up within the specified timeframes and that compliance be monitored.

Concur

Target date for completion: December 31, 2012

To ensure mental health patients receive follow-up within the specified VHA timeframes and to identify opportunities for improvement, the outpatient psychiatry nurse manager in collaboration with the mental health quality consultant, studied and developed a mental health follow-up process map. Through process mapping, both system and patient barriers were identified and the following improvement measures were implemented:

The acute psychiatry inpatient staff notifies the outpatient mental health RN Care Coordinators of daily discharges to ensure mental health follow-up appointments are scheduled.

Acute psychiatry inpatient staff identifies patient barriers to accessing outpatient care on discharge in an effort to mitigate psychosocial barriers and ensure mental health continuity care (i.e., Transportation, Homelessness, lack of support, etc.). Veterans receive an appointment reminder phone call 48 hours post discharge.

Mental Health RN Care Coordinators monitor follow-up appointments in an electronic spreadsheet and telephones all Veterans who are not seen within 7 days.

Mental Health RN Care Coordinators contact and reschedule patients within 14 days post discharge if they fail to show for their 7 day post hospital follow-up visit. If unable to speak with the patient, the rescheduled appointment will be mailed.

A CPRS template titled *Missed MH appointment* is used to follow-up on no-shows and to document the reason for the missed appointment.

Compliance with VHA mental health follow-up measure will be monitored on a monthly basis and reported to Mental Health Executive Committee until the 75 percent national benchmark is sustained for 3 consecutive months. The monthly audit will include all patients discharged from the acute psychiatry unit.

Recommendation 9. We recommended that all discharged MH patients who are on the high risk for suicide list receive follow-up at the required intervals and that compliance be monitored.

Concur

Target date for completion: December 31, 2012

In addition to implementing the corrective actions from recommendation #8, the Suicide Prevention Case Manager will meet with high risk veterans prior to discharge to establish rapport, provide support during the high risk period and inform veteran of follow-up appointments.

Veterans identified as high risk will follow up with a suicide prevention case manager in person or by phone for 30 days post discharge in the following intervals: 0–7 Days, 8–14 Days 15–21 Days, and 22–30 Days.

Mental Health follow-up appointments for high risk veterans will be monitored on a monthly basis and reported to Mental Health Executive Committee until 85 percent compliance is sustained for 3 consecutive months. The monthly audit will include all high risk veterans discharged from the acute psychiatry unit.

Recommendation 10. We recommended that processes be strengthened to ensure that discharge instructions address diet and the initial follow-up appointment.

Concur

Target date for completion: November 23, 2012

Written discharge instructions to the patients will include diet instructions as a mandatory forced field. A multidisciplinary team has been established. The team includes: hospitalist, cardiologist, nutritionist, pharmacist, RN care manager and RN to address issue of CHF admissions and readmissions. Revision of the discharge

instructions template will be made through our clinical application coordinators to meet compliance with all parameters as stated in the VHA Handbook (1907.01-Health Information Management & Health Records).

This team is creating standardized and patient-centered educational materials, including revision of discharge instructions. Interns, residents, and ward attending will be educated on the required components of discharge instructions.

In addition, the patient will have their follow-up appointment or the process for obtaining their follow-up appointment written in their discharge instructions. The following process has been developed to assure compliance.

The process includes creation of a "discharge note" completed by the inpatient treating team that is immediately viewable by PACT at the time of discharge. The PACT provider and RN Care Manager are added as additional signers to the note. The PACT RN Care Manager will review the note at time of discharge and will ensure that recommended follow-up appointments are scheduled and patient notified.

Twenty five random chart audits will be completed monthly by the multidisciplinary team and this data be reported to CPEC until 90% or greater compliance has been achieved for 3 consecutive months.

Recommendation 11. We recommended that processes be strengthened to ensure that safety inspections are conducted on all ceiling lifts in the SCI Center and documented.

Concur

Target Date: November 30, 2012

Following the OIG visit, all of the SCI Center patient ceiling lifts were inspected for safety on August 30, 2012 by a qualified engineering firm. The safety inspections included all the post installation and structural elements of the Patient Safety Alert checklist and the manufacturer's instructions. The results will be reported by the Safe Patient Handling Coordinator to the Safe Patient Handling Committee at the October 2012 meeting. The Patient Safety Alert checklists will be completed for all of the SCI ceiling lifts by the Safe Patient Handling Coordinator by October 31, 2012 and results will be reported to the Safe Patient Handling Committee at the November 2012 meeting.

The ongoing Preventative Maintenance (PM) program for the ceiling lifts was reviewed and enhanced to include VA required and manufacturer's recommended maintenance requirements. The enhancements were completed September 17, 2012. The PM program will also be improved with a service contract to perform annual PM and safety testing, per the manufacturer's instructions and to include all the elements of the Patient Safety Alert.

The Assistant Chief, Engineering Service, will develop and implement a tracking database for each ceiling lift through VISTA PMI/work orders by the end of

November 2012, and ensure that any Engineering actions are completed within 14 days of reporting. Monitoring of the PM and annual safety testing is reported quarterly by the Safe Patient Handling Coordinator to the Safe Patient Handling Committee. Completed checklists are reported by the Safe Patient Handling Coordinator to the Safe Patient Handling Committee, at a minimum each quarter.

The Chief, Engineering Service and Safe Patient Handling Coordinator will ensure that all new contracts for ceiling lift installation will follow VHA SPH and manufacture's pre and post installation checklist certifications and that the VA pre and post checklist will be completed. The Patient Safety Manager, in collaboration with the Safe Patient Handling Coordinator will also review to insure that all updates, alerts and checklists are completed in a timely fashion.

The Safe Patient Handling Unit Peer Program continues to be strengthened. Safe Patient Handling Unit Peer Leaders continually reinforce with staff that it is the end-user-responsibility to do a visual inspection of each lift prior to use. Prior to each use, the end user checks the lifting straps for loose threads or fraying, they confirm that the hand controls are working, and confirm that the charging functions are working. Any non-functioning lifts or any concerns noted during visual inspections are immediately taken out of service, tagged and reported to the Engineering emergency help desk until Engineering has evaluated, inspected, and cleared it for safe use. An SOP, detailing the safe use of patient lifts is to be completed by October 30, 2012.

All staff that use patient lifts are trained and competencies completed prior to use and on an annual basis. The completion of staff competencies are tracked and reported annually, (two months after the end of the fiscal year), with the exception of new staff members, which are reported quarterly by the Safe Patient Handling Coordinator to the Safe Patient Handling Committee.

Recommendation 12. We recommended that processes be strengthened to ensure that all required participants or their designees consistently attend EOC rounds.

Concur

Target date for completion: December 31, 2012

The EOC Rounds Team membership has been reviewed and updated to include all expected participation as described in the 2007 DUSHOM memorandum. An EOC Rounds Health System Policy will be developed and will include the required participants, the performance expectations and the permissible delegations of designees. Delegation by required participants to designees will only be permitted for 10% of rounds.

Training will be provided to the Senior Management, Service and Healthcare Group (HCG) Chiefs, Supervisors, Environmental Rounds Inspection teams, designees ensuring consistency in inspection practices and expectations throughout facility EOC rounds. The training commenced on September 24, 2012 and included all the required

elements (both OIG and Joint Commission) for EOC rounds. This training will be completed for 90% of the aforementioned staff by November 30, 2012.

Weekly attendance will be reported within 2 days of completed rounds to the responsible Senior Management member for review and appropriate action. Required attendance is monitored through the EOC Committee dashboard, recorded in meeting minutes and reported to the Executive Safety, Health and Leadership Council on a monthly basis. The measure of success threshold is 90% and must be sustained for 4 months. When the appropriate attendance is maintained through March 2012, the action is closed.

Recommendation 13. We recommended that processes be implemented to report results of tracking and trending of inter-facility transfers to the Organizational Excellence Board and to incorporate education on inter-facility transfers into new resident orientation.

Concur

Target date for completion: December 1, 2012

The transfer office has been placed on both the OEB and the MEC agendas as a standing quarterly report and has already reported in both forums and will continue to do so quarterly. The transfer office has requested and been granted a forum at new resident orientation for global resident orientation. All Chief Residents have received the transfer process education and presently serve as a resource for new residents. Currently, prior to daily multidisciplinary bed huddle, the transfer coordinator will conduct education for new residents and provide them with written materials. The transfer office will continue to work with individual residents to assure that all components of inter-facility transfers are adhered to and fully documented in CPRS.

Recommendation 14. We recommended that processes be strengthened to ensure that EOC deficiencies are corrected within the required timeframe and that action plans are submitted for deficiencies not corrected within the required timeframe.

Concur

Target date for completion: December 31, 2012

EOC rounds deficiency reports (including all outstanding deficiencies) are generated and communicated to the appropriate HCG/Service Chiefs and the Associate Director on a weekly basis. The weekly EOC Deficiency reports will be reviewed by the Senior Management Team for appropriate action and correction of deficiencies within the 14-day time frame. The weekly reports will also be reviewed once a week on the Daily Briefing call. If the timeframe to correct a deficiency is longer than 14 days, an action plan is implemented by the service with a target date for completion. Compliance of timely correction of deficiencies within 14 days and the completion of required action plans for items not corrected within 14 days will be monitored through the EOC

Committee dashboard, recorded in meeting minutes, reported to the Executive Safety, Health and Leadership Council on a monthly basis.

Monthly audits of completed deficiencies will be conducted by the Associate Director, Chief Engineering Service, Chief Environmental Management Service and Chief, Safety and Emergency Management Service and will be reported and monitored through EOC Committee dashboard, recorded in meeting minutes and reported to the Executive Safety, Health and Leadership Council on a quarterly basis.

In addition to the training action plan included in recommendation #12, the training will include the requirements and expectations for correcting EOC deficiencies within the required timeframe and that action plans are submitted for deficiencies not corrected within the required time frame.

A Program Support Assistant vacancy is being restructured within the newly formed Safety and Emergency Management Service to serve as the EOC Coordinator. This position will ensure timely entry of deficiencies into the electronic tracking system, Performance Logic, and will develop and provide monitoring reports. Reports will also be reviewed for trends and further opportunities for improvement. EOC round deficiencies will be aggregated and reviewed by the EOC Committee by December 31, 2012, to ensure compliance with timeframes, opportunities for improvement, need for corrective action plans to address organizational deficiencies, and ongoing maintenance issues. The recommendations from this assessment will be tracked and reported to the Executive Safety and Health Leadership Council quarterly.

Recommendation 15. We recommended that facility managers conduct a comprehensive EOC inspection of the facility and take appropriate actions to correct identified general cleanliness and maintenance issues.

Concur

Target date for completion: December 31, 2012

In addition to the aforementioned action plans for Recommendations #12 and #14, Senior Management, Service/HCG Chiefs, Environmental Rounds Inspection teams and designees, and appropriate Supervisors will conduct a comprehensive facility wide EOC inspection to specifically look at the cleanliness and maintenance deficiencies. A comprehensive plan will be developed to correct immediately or further develop an action plan which may include station level projects, minor improvement projects, new furniture, new equipment, etc. Action requiring projects or other resource requirements will be prioritized and placed into a facility plan. The first area of emphasis to be inspected will be the acute patient care areas and will be completed by November 30, 2012. The assessment of the facility, corresponding actions plans and target dates for completed actions will be concluded by the end of the first quarter.

All findings from the comprehensive EOC facility inspection will be submitted to the EOC Committee by December 31, 2012, for review. If the timeframe to correct a deficiency is longer than fourteen days, an action plan will be implemented with a target

date for completion. The EOC Dashboard will include these deficiencies and will be reported to the Executive Health, Safety and Leadership Council Executive Leadership Board on a monthly basis until the identified deficiencies are completed and a sustainable measure of success of 90% or greater is reached. This process is monitored monthly for 4 months for a sustainable process. Upon completion of the comprehensive EOC inspection, the EOC Environmental Rounds teams will continue to conduct weekly comprehensive inspections throughout the facility to ensure compliance of the EOC standards. All EOC rounds will specifically focus on facility cleanliness, ceiling tiles, high dusting and cleaning, floor tiles and repair, wall penetrations, wall repairs and painting, and furniture integrity

Current vacancies within EMS and Maintenance and Operations (Engineering Service) are high priority for recruitment. Human Resources will provide weekly status reports to the Associate Director, akin to the focus placed on Mental Health vacancies. An existing vacancy in Engineering Service will be restructured as a Chief of Maintenance to allow focus on facility maintenance issues. A recently vacated Program Specialist position in EMS will be restructured to focus on Quality Assurance and staff training to ensure consistent and standardized cleaning processes throughout the facility.

OIG Contact and Staff Acknowledgments

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