Department of Veterans Affairs
Office of Inspector General

Report No. 08-02565-204

Combined Assessment Program Review of the VA Western New York Healthcare System Buffalo, New York

August 31, 2009

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 fraud and integrity awareness training 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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Table of Contents

Executive Summary

Introduction

During the week of July 13–17, 2009, the OIG conducted a Combined Assessment Program (CAP) review of the VA Western New York Healthcare System (the system), Buffalo, NY. The purpose of the review was to evaluate selected operations, focusing on patient care administration and quality management (QM). During the review, we also provided fraud and integrity awareness training for 200 system employees. The system is part of Veterans Integrated Service Network (VISN) 2.

Results of the Review

This CAP review covered six operational activities. We identified the following organizational strengths and reported accomplishments:

- Computer Assisted Design/Computer Assisted Manufacturing (CAD/CAM) dentistry.

- Improved access to substance abuse (SA) treatment.

We made recommendations in all six of the activities reviewed. For these activities, system managers needed to:

- Ensure that implementation and efficacy of corrective actions identified through the root cause analysis (RCA) process are reported timely.

- Ensure the analysis of system-wide patient complaint data for overall trends.

- Monitor the use of the copy and paste functions and report trends to the Executive Committee of the Medical Staff (ECMS).

- Correct identified infection control (IC) deficiencies at the Batavia division.

- Ensure proper storage of oxygen cylinders at the Batavia division.

- Ensure that professional practice evaluations are fully implemented for all privileged physicians and that ECMS minutes reflect discussions regarding performance data.

- Ensure that discharge summaries and instructions include all required elements and that the information is consistent.

- Require monthly medication reviews for all community living center (CLC) patients and monitor compliance.

- Ensure that magnetic resonance imaging (MRI) screening forms be accessible timely in the computerized patient record system (CPRS) and that the forms contain complete patient identification information.

This report was prepared under the direction of Jeanne Martin, Associate Director, Bedford Office of Healthcare Inspections.

Comments

The VISN and System Directors agreed with the CAP review findings and recommendations and provided acceptable improvement plans. (See Appendixes A and B, pages 13–18 for full text of the Directors' comments.) We will follow up on the planned actions until they are completed.

(original signed by:)
JOHN D. DAIGH, JR., M.D.
Assistant Inspector General for
Healthcare Inspections

Introduction

Profile

Organization. The system provides a broad range of inpatient and outpatient health care services at two divisions located in Buffalo and Batavia, NY. Outpatient care is also provided at seven community based outpatient clinics (CBOCs) in Dunkirk, Lackawanna, Jamestown, Lockport, Olean, Niagara Falls, and Warsaw, NY. The system is part of VISN 2 and serves a veteran population of about 100,000 throughout 10 counties in western New York.

Programs. The Buffalo division provides comprehensive health care through primary care, acute care, (medicine, surgery, and mental health (MH)), and long-term care services. It is the main referral center for cardiac surgery, cardiology, and cancer care for central and western New York and northern Pennsylvania.

The Batavia division provides primary care and long-term care services. It also has a male post-traumatic stress disorder (PTSD) residential unit and a female combined sexual trauma and PTSD residential unit.

Affiliations and Research. The system is affiliated with the State University of New York at Buffalo's School of Medicine and Biomedical Sciences and annually provides training for 99 residents. It also provides training in other health care professions, such as audiology, dentistry, nursing, pharmacy, health care administration, occupational and physical therapy, psychology, speech pathology, and social work. The system's fiscal year (FY) 2009 research program has 200 approved projects and a budget of more than $4 million. Important areas of research include oncology, endocrinology, and pulmonary disease.

Resources. In FY 2008, the system's medical care expenditures totaled $197 million. FY 2008 staffing was 1,690 full-time employee equivalents (FTE), including 115 physician and 503 nursing FTE.

Workload. In FY 2008, the system treated more than 40,000 unique patients and provided over 37,300 inpatient days in the hospital. In addition, the system provided over 36,300 inpatient days in the CLC[1] units. The inpatient care

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[1] A CLC (formerly called a nursing home care unit) provides compassionate, person-centered care in a safe and homelike environment to eligible veterans who require a nursing home level of care.

workload totaled 4,768 discharges, and the average daily census (including CLC patients) was 201. Outpatient workload totaled more than 449,600 visits.

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 fraud and integrity awareness training 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 work areas; interviewed managers and employees; and reviewed clinical and administrative records. The review covered the following six activities:

- Coordination of Care.

- Environment of Care (EOC).

- Medication Management.

- MRI Safety.

- Physician Credentialing and Privileging (C&P).

- QM Program.

The review covered system operations for FY 2008 and quarter 1 of FY 2009 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 (*Combined Assessment Program Review of the VA Western New York Healthcare System, Buffalo, New York,* Report No. 05-03096-137, May 2, 2006). In that

report, we recommended that managers improve drainage in a shower on the SA residential rehabilitation unit. During our follow-up review, we found sufficient evidence that managers had implemented appropriate actions to address the recommendation, and we consider the issue closed.

During this review, we also presented fraud and integrity awareness briefings for 200 employees. These briefings covered procedures for reporting suspected criminal activity to the OIG and included case-specific examples illustrating procurement fraud, conflicts of interest, and bribery.

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

Organizational Strengths

Computer Assisted Design/Computer Assisted Manufacturing Dentistry

The system's Dental Service implemented CAD/CAM technology for the fabrication of ceramic dental crowns. This innovative technology allows dentists to fabricate and cement dental crowns in a single visit. Prior to the implementation of this technology, it took two to three separate dental visits over a 4–6 week period to complete the procedure utilizing conventional techniques. CAD/CAM technology has increased access to dental care and patient satisfaction. Additionally, the system realized a significant cost savings. During the period June 2008–June 2009, 281 CAD/CAM crowns were fabricated for a total savings of $22,480.

Improved Access to Substance Abuse Treatment

Managers developed a system redesign initiative to improve access to SA treatment. Prior to implementation of the initiative, patients seeking SA treatment waited an average of 7–23 days to receive initial appointments for evaluation, which contributed to a high no-show rate. Additionally, consults for SA treatment took an average of 22 days to process.

Managers initiated a walk-in intake process that allows providers to see patients seeking SA treatment the same day they present to the facility. Also, the intake providers process SA treatment consults daily. Since implementation in March 2009, the program has eliminated the waiting time for intake evaluations, decreased the no-show rate from

22 percent to 2 percent, and reduced the consult response time to 2–3 days.

Results

Review Activities With Recommendations

Quality Management Program

The purpose of this review was to evaluate whether the system had a comprehensive QM program designed to monitor patient care quality and whether senior managers actively supported the program's activities. We evaluated policies, performance improvement (PI) data, and other relevant documents, and we interviewed appropriate senior managers, patient safety employees, and the QM Coordinator.

The system's QM program was generally effective, and senior managers supported the program through participation in and evaluation of PI initiatives and through allocation of resources to the program. However, we identified three areas that needed improvement.

RCA Process. We found that RCA[2] reviews were thorough. However, information from the Veterans Health Administration (VHA) National Center for Patient Safety (NCPS) database, known as SPOT (not an acronym), showed that between May 1, 2008, and June 30, 2009, 45 percent of the identified corrective actions that were due had not been reported as implemented. Additionally, results of monitoring activity for 50 percent of the outcome measures that were due had not been reported. VHA regulations[3] require that corrective actions identified through RCA reviews be implemented and monitored for efficacy.

Patient Complaint Data. The system collected patient complaint data and appropriately referred issues to care line managers for resolution. However, there is an expectation in VHA regulations[4] that all complaints received throughout the organization will be analyzed for overall trends. At the time of our review, analysis of system-wide patient complaint data was not being conducted.

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[2] An RCA is an in-depth analysis of an adverse event to determine why the event occurred and to develop corrective actions to prevent future occurrences.

[3] VHA Handbook 1050.01, *VHA National Patient Safety Improvement Handbook*, May 23, 2008.

[4] VHA Handbook 1003.4, *Patient Advocacy Program*, September 2, 2005.

Medical Record Documentation. VHA regulations[5] and VISN policy require that managers monitor the copy and paste functions in CPRS for inappropriate use and report violations to the ECMS for corrective actions. While VHA requirements for monitoring have been in place since 2006, system managers did not begin monitoring the use of these functions until January 2009. Additionally, this information was not trended or provider specific; consequently, the data were not useful in the identification of system issues.

Recommendation 1 We recommended that the VISN Director ensure that the System Director requires that implementation and efficacy of corrective actions identified through the RCA process be reported timely.

Recommendation 2 We recommended that the VISN Director ensure that the System Director requires the analysis of system-wide patient complaint data for overall trends.

Recommendation 3 We recommended that the VISN Director ensure that the System Director requires that managers monitor the use of the copy and paste functions and report trends to the ECMS.

The VISN and System Directors agreed with the findings and recommendations. They reported that responsible care line managers will report the status of RCA action items to the Health Systems Committee until items are fully resolved. The patient advocate will analyze patient complaint data, and care line managers will develop action plans for problematic areas. The patient advocate will report trends and actions to the appropriate committee. The Directors also reported that Health Information Management managers will develop a process to monitor the use of the copy and paste functions and report monthly to the Medical Records Committee. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

Environment of Care The purpose of this review was to determine whether the system maintained a safe and clean health care environment. VHA facilities are required to establish a comprehensive EOC program that fully meets VHA, NCPS, Occupational Safety and Health Administration, National Fire Protection Association (NFPA), and accreditation requirements. At the Buffalo division, we inspected the

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

following areas: (a) two medical/surgical units, (b) the intensive care unit, (c) the acute MH unit, and (d) one CLC unit. At the Batavia division, we inspected three CLC units.

The inspected areas were clean and well maintained, and nurse managers expressed satisfaction with the housekeeping staff assigned to their areas. We reviewed fire drill reports for April 2008–April 2009 and found that managers conducted fire drills as required and assessed personnel and equipment performance. Additionally, we determined that managers identified environmental hazards on the acute MH unit that potentially posed threats to patients. The system provided documentation of risk assessment and abatement tracking of safety issues previously identified on the unit, and unit staff completed suicide risk training. However, we identified two areas at the Batavia division that needed improvement.

IC. VHA facilities are required to implement and maintain effective IC programs. To fully meet the requirement, emergency call cords should be made of materials (for example, vinyl or plastic) that can be cleaned and disinfected. Cloth or materials that absorb moisture can serve as a reservoir for microorganism growth. The cords should also be of a length that will prevent them from coming into contact with floor surfaces. On the three CLC units, we found call cords made of cloth in congregate and patient bathrooms, and the cords were touching the floors. While we were onsite, managers replaced the cloth cords with plastic ones, but the length of the replaced cords still allowed them to touch floor surfaces.

Additionally, we found two storage rooms where clean linens and patient protective equipment were stored on the floor in plastic and paper bags. Clean items must be stored in appropriate containers that are not in contact with floor surfaces.

Safety. The NFPA requires that oxygen cylinders be stored securely and in a location where they are protected from potential tampering and where heavy objects cannot strike or fall on them. On one CLC unit, we found that oxygen cylinders were stored in a corridor accessible to the public.

Recommendation 4   We recommended that the VISN Director ensure that the System Director corrects identified IC deficiencies at the Batavia division.

Recommendation 5   We recommended that the VISN Director ensure that the System Director requires the proper storage of oxygen cylinders at the Batavia division.

The VISN and System Directors agreed with the findings and recommendations. They reported that emergency pull cords made of cloth have been replaced with plastic cords and that the cords have been shortened to the appropriate length. They also reported that patient clothing and individual protective equipment will be stored on shelves and that oxygen cylinders were moved to a secured location for storage. The corrective actions are acceptable, and we consider these two recommendations closed.

Physician Credentialing and Privileging

The purpose of this review was to determine whether VHA facilities have consistent processes for physician C&P. For a sample of physicians, we reviewed selected VHA required elements in C&P files and provider profiles.[6] We also reviewed meeting minutes during which discussions about the physicians took place.

We reviewed 16 physicians' C&P files and profiles. The physicians were either appointed to the medical staff or reprivileged by the medical staff in the past 12 months. We found that licenses to practice were current and that managers obtained appropriate primary source verification[7] for all physicians reviewed. However, we identified an area that needed improvement.

Professional Practice Evaluation. VHA regulations require that clinical managers develop thorough professional practice plans with specific competency criteria for all privileged physicians. Although clinical managers had developed service-specific criteria for professional practice evaluations at the time of our CAP review, implementation of the process did not commence until May 2009. Consequently, only 2 (13 percent) of the 16 physicians had adequate data to support the privileges granted.

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[6] VHA Handbook 1100.19, *Credentialing and Privileging*, November 14, 2008.
[7] Primary source verification is documentation from the original source of a specific credential that verifies the accuracy of a qualification reported by an individual health care practitioner.

Additionally, ECMS meeting minutes did not reflect detailed discussions about performance data.

Recommendation 6   We recommended that the VISN Director ensure that the System Director requires that professional practice evaluations for all privileged physicians are fully implemented and that ECMS minutes reflect discussions regarding performance data.

The VISN and System Directors agreed with the findings and recommendation. They reported that all physician profile folders will contain professional practice evaluation data. Additionally, the ECMS will include discussions about professional practice data in meeting minutes and will submit quarterly reports to system leadership. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

Coordination of Care

The purpose of this review was to evaluate whether inpatient intra-facility transfers, discharges, and post-discharge MH care were coordinated appropriately over the continuum of care and met VHA and accreditation standards. Coordinated transfers, discharges, and post-discharge MH care are essential to integrated care processes and optimal patient outcomes.

We found that providers managed intra-facility transfers appropriately and that MH discharge documentation included follow-up MH appointments and information about emergency MH services. However, we identified an area that needed improvement.

Discharges. VHA regulations[8] require that specific information be included in discharge summaries and discharge instructions. We reviewed 22 medical records and found that in 21 (95 percent) of the records, various elements required by VHA were missing in either the discharge summaries or the discharge instructions. This created inconsistencies between the summaries and the instructions. Additionally, when the elements were included in both documents, they were not always consistent. For example, we found five records where diet instructions differed between the summaries and the instructions.

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[8] VHA Handbook 1907.01.

Recommendation 7   We recommended that the VISN Director ensure that the System Director requires that discharge summaries and discharge instructions include all required elements and that information in the summaries and instructions is consistent.

The VISN and System Directors agreed with the findings and recommendation. They reported that clinical managers will redesign the discharge summary template and discharge instruction note to include all required elements. They also reported that Health Information Management managers will monitor the use of the redesigned template and note for compliance and will report results quarterly. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

Medication Management

The purpose of this review was to evaluate whether VHA facilities had developed effective and safe medication management practices. We reviewed selected medication management processes on the medical/surgical, MH, and CLC units.

The system had a designated Bar Code Medication Administration Program coordinator. Reassessments for 154 administered doses of PRN[9] pain medications reviewed for the period of April 26–May 3, 2009, were documented. However, we identified an area that needed improvement.

Monthly Medication Reviews. System policy requires that pharmacists review the medications of all CLC residents each month. Our inspection covered the previous 12 months. We reviewed five patients' medical records on each of the three CLC units (a total of 60 required reviews per unit). We found that pharmacists completed all the monthly medication reviews on two of the three units. On the third unit, we found that only 46 (77 percent) of the required 60 monthly reviews were completed.

Recommendation 8   We recommended that the VISN Director ensure that the System Director requires that pharmacists perform monthly medication reviews for all CLC patients and that compliance is monitored.

The VISN and System Directors agreed with the findings and recommendation. They reported that pharmacists will review all CLC residents' medications monthly and that pharmacy

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[9] PRN is a Latin abbreviation [L *pro re nata*] meaning as needed or as the circumstances require.

managers will monitor compliance and report findings to the appropriate committee quarterly. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

Magnetic Resonance Imaging Safety

The purpose of this review was to evaluate whether the system maintained a safe environment and had safe practice procedures in the MRI area. Safe MRI procedures minimize risk to patients, visitors, and staff and are essential to quality patient care.

We inspected the MRI area, examined medical and training records, reviewed relevant policies, and interviewed key personnel. We determined that the system had adequate safety policies and conducted a risk assessment of the environment, as required by The Joint Commission. The system had appropriate signage and barriers to prevent unauthorized or accidental access to the MRI area. Patients in the magnet room were directly observed at all times. Two-way communication was available between the patient and the MRI technologist, and the patient had access to a push-button call system while in the scanner.

We reviewed the training records of five MRI personnel and found that all had completed appropriate safety training specific to their MRI zone level access. Additionally, we reviewed the training records of six support (non-MRI) personnel who had access to the MRI area and found that all had completed MRI safety training. However, we identified an area that needed improvement.

Screening. All patients should undergo safety screening prior to MRI procedures.[10] Radiology personnel record patient screening information on MRI screening forms that are later scanned into the patient's medical record. We reviewed the medical records of 10 patients who received an MRI during a 3-day period 2 months prior to our visit. None of the electronic medical records contained the MRI screening form. We were unable to locate paper copies of the forms for four patients. Of the six forms we were able to locate, two did not contain complete patient identification information. In addition, we found forms from the past 3 months that had not yet been scanned into patient records.

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[10] VA Radiology, *Online Guide,* Sec. 4.3, MRI Safety, http://vaww1.va.gov/Radiology/page.cfm?pg=167.
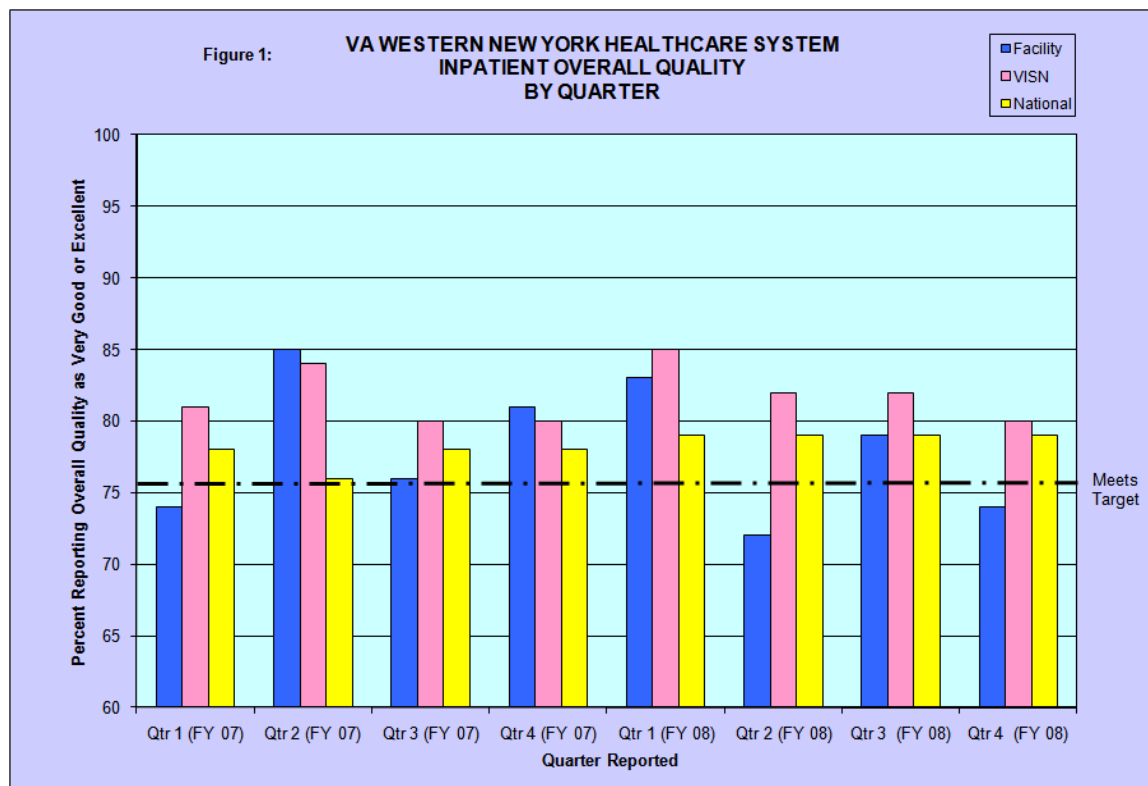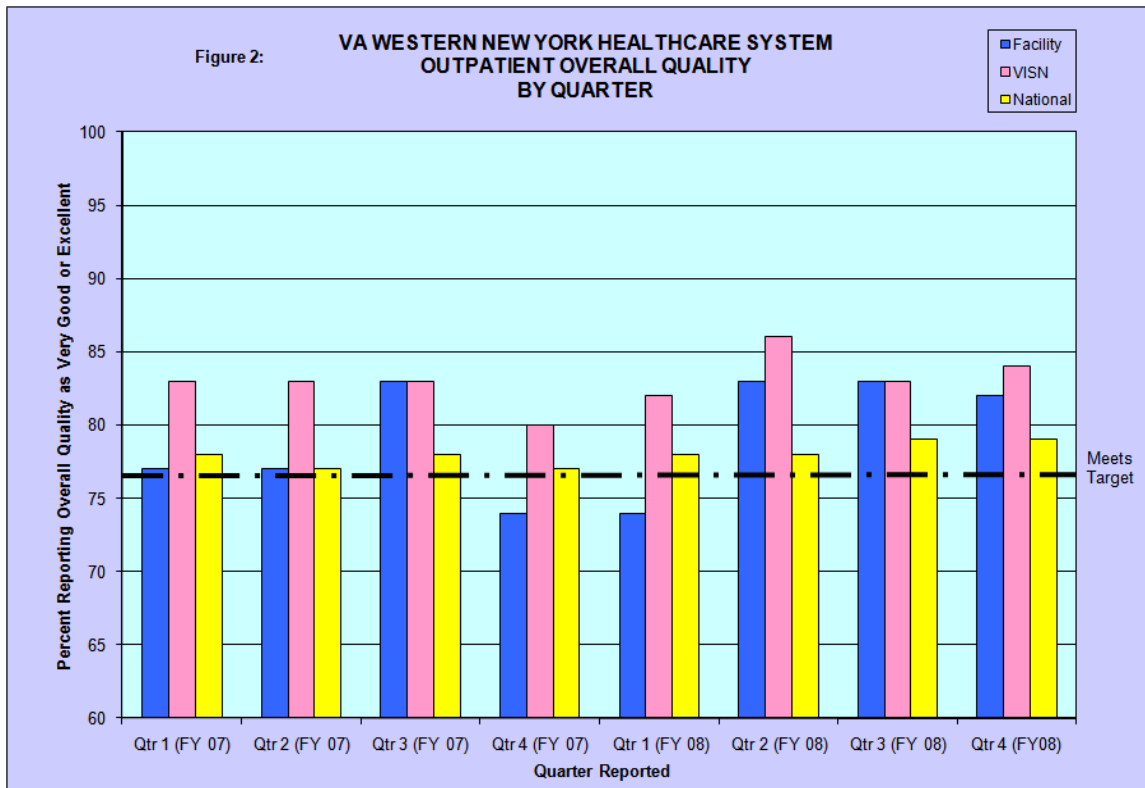
Recommendation 9   We recommended that the VISN Director ensure that the System Director requires that MRI screening forms be accessible timely in CPRS and that the forms contain complete patient identification information.

The VISN and System Directors agreed with the findings and recommendation. They reported that Radiology, Clinical Applications, and Information Systems managers will develop a process to ensure that MRI screening forms are completed and available. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

VHA Satisfaction Surveys

VHA has identified patient and employee satisfaction scores as significant indicators of facility performance. Patients are surveyed monthly, and data are summarized quarterly. Figure 1 below and Figure 2 on the next page show the system, VISN, and national overall inpatient and outpatient satisfaction scores for FYs 2007 and 2008. Target scores are noted on the graphs.

Figure 1: VA WESTERN NEW YORK HEALTHCARE SYSTEM INPATIENT OVERALL QUALITY BY QUARTER

Figure 2: VA WESTERN NEW YORK HEALTHCARE SYSTEM OUTPATIENT OVERALL QUALITY BY QUARTER

Employees are surveyed annually. Figure 3 below shows the system's overall employee scores for 2007, 2008, and 2009. Since no target scores have been designated for employee satisfaction, VISN and national scores are included for comparison.

Figure 3: VA ALL EMPLOYEE SURVEY OVERALL SATISFACTION
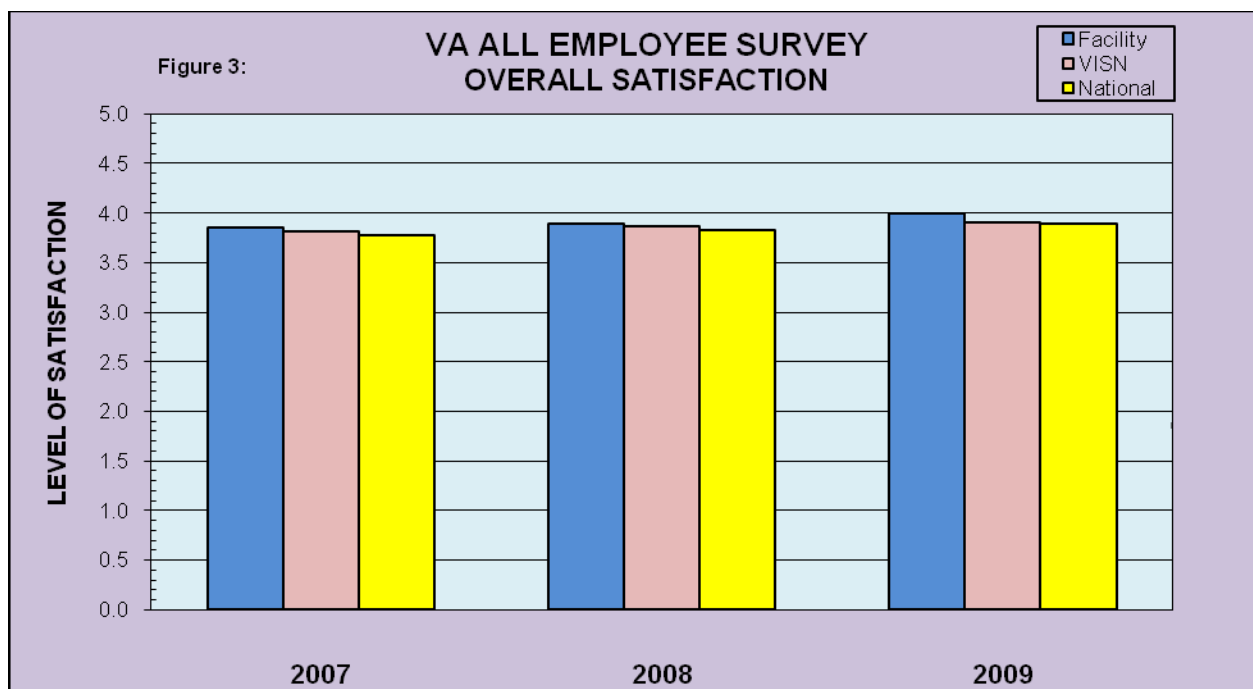
VISN Director Comments

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

Date: August 13, 2009

From: Director, VA Healthcare Network Upstate New York (10N2)

Subject: **Combined Assessment Program Review of the
                 VA Western New York Healthcare System, Buffalo,
                 New York**

To: Director, Bedford Office of Healthcare Inspections (54BN)

                 Director, Management Review Service (10B5)

VISN 2 concurs in all findings and recommendations.

    (original signed by:)
STEPHEN L. LEMONS, Ed.D.

System Director Comments

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

Date: August 10, 2009

From: Director, VA Western New York Healthcare System (528/00)

Subject: **Combined Assessment Program Review of the VA
                 Western New York Healthcare System, Buffalo,
                 New York**

To: Director Bedford Office of Healthcare Inspections (54BN)

                 Director, Management Review Service (10B5)

We concur with your findings and recommendations.

(original signed by:)
WILLIAM F. FEELEY, MSW, FACHE

Comments to Office of Inspector General's Report

The following Director's comments are submitted in response to the recommendations in the Office of Inspector General report:

<u>**OIG Recommendations**</u>

Recommendation 1. We recommended that the VISN Director ensure that the System Director requires that implementation and efficacy of corrective actions identified through the RCA process be reported timely.

Concur   **Target Completion Date**:

RCA Actions/HSC Agenda – 8/13/09

Qtly Rpt to LLC – 9/13/09

Action Plan: Announcement of OIG Recommendation at Health Systems Committee meeting on 8/13/09. Health Systems Committee will include on agenda monthly RCA action items. Status of implementation monitoring to be reported monthly until resolution. Discussion and status will be documented in the Health System Committee minutes. Care Line Managers will assign manager responsible for assigned RCA action item. Chief of Staff will ensure that this is done. Report to be presented at Local Leadership Council (LLC) quarterly.

Recommendation 2. We recommended that the VISN Director ensure that the System Director requires the analysis of system-wide patient complaint data for overall trends.

Concur   **Target Completion Date**: 11/2/09

Qtly Rpt to Accreditation Cmte & LLC

Action Plan: The Patient Advocate will identify the Care Line Manager responsible for action plans of trended data reflecting problematic areas. Care Line Manager will return action plan to the Patient Advocate who will include attachment with the quarterly Patient Advocate report beginning 4th Qtr FY 09. The Accreditation Care Planning Sub-Committee will review action plans and follow up actions and document status until resolution. Report to be presented at the Local Leadership Council quarterly with trended themes for improvement.

Recommendation 3. We recommended that the VISN Director ensure that the System Director requires that managers monitor the use of the copy and paste function and report trends to ECMS.

Concur   **Target Completion Date**:

Develop Review Process/Initiate Data Collection – 7/16/09

Qtrly Rpt to Accreditation Cmte & Leadership – 11/2/09

Action Plan: The Health Information Management System (HIMS) Manager will develop a monthly review process to effectively monitor the importing/copying (copy/paste) of text into CPRS that allows for provider specific profiling. Beginning 7/1/09 the HIMS Manager will initiate data collection. Beginning with 4th Qtr FY 09 results, the HIMS Manager will report the trended outcomes quarterly to the Medical Records Committee. The Chair of the Medical Records Committee will forward provider specific data to the section chiefs. The section chiefs will review the results with the specific providers telling them to cease and desist the copy/past practice. The section chief will also include this data into the provider profiling package. Verification of discussion (memo format) with the individual provider will be sent to the Chair of the Medical Records Committee. The Chair of the Medical Records Committee or designee will report the copy/paste data and action outcomes to the Accreditation Care Planning Sub-Committee beginning with the 4th Qtr Report. A monthly report will also be presented to Leadership for the next 12 months.

Recommendation 4. We recommended that the VISN Director ensure that the System Director corrects identified IC deficiencies at the Batavia division.

Concur   **Completed Date**: 7/16/09

Action Plan: Cloth cords have been replaced with plastic cords that can be cleaned. The plastic cords have been shortened so they no longer touch the floor but could be reached if a patient were on the floor. Clean linens and patient protective equipment (patient clothing & individual protective equipment) will be stored on shelves in the Personal Clothing Room on ground floor. (Note: the clean linen was laundered patient clothing waiting for return to family).

Recommendation 5. We recommended that the VISN Director ensure that the System Director requires proper storage of oxygen cylinders at the Batavia division.

Concur   **Completed Date**: 7/16/09

Action Plan: A room has been designated for storage on Oak Lodge to house oxygen cylinders safely to meet NFPA 99 standards. The room has capability for locking.   Oxygen cylinders have been moved to the designated location. Oxygen cylinders have been added as a regular part of the Batavia EOC rounds checklist.

Recommendation 6. We recommended that the VISN Director ensure that the System Director requires that professional practice evaluations for all privileged physicians are fully implemented and that ECMS minutes reflect discussions regarding performance data.

Concur   **Target Completion Date**:

Discussion at ECMS – 8/13/09

Qtrly Rpt to Leadership – 9/09

Action Plan: Plans for professional practice evaluations have been in place since May 2009. Section chiefs are to ensure collection of focused and ongoing professional practice evaluation data for inclusion in provider profiling folders. Detailed discussion of all physician performance data prior to privileging will be included in the ECMS meeting minutes beginning August 2009.   A report will be presented to Leadership quarterly.

Recommendation 7. We recommended that the VISN Director ensure that the System Director requires that discharge summaries and discharge instructions include all required elements and that information in the summaries and instructions is consistent.

Concur   **Target Completion Date**: 10/1/09

Action Plan: Health Information Management System (HIMS) Manager to review VHA Handbook 1907.01 to identify the required elements of the discharge summary and discharge instruction note. HIMS Manager will communicate results of this review to the Chief of Staff (COS). The COS will redesign the discharge summary template to include all required elements. The Nurse Executive and COS will redesign the discharge instruction note to include all required elements. The COS will investigate with CAC the possibility of designing a discharge order set that includes all discharge instruction note requirements.   COS will investigate the capability of discharge order set required elements being automatically dropped into the discharge instruction note. Education for providers and RN nursing staff will be completed by 10/1/09. Beginning with 10/1/09 discharges the HIMS Manager will collect data on provider specific compliance with required documentation elements for discharge summary and discharge instruction note and report to the Medical Record Committee quarterly.

Recommendation 8. We recommended that the VISN Director ensure that the System Director requires that pharmacists perform monthly medication reviews for all CLC patients and that compliance is monitored.

Concur   **Target Completion Date**:

Medication Reviews/Documentation in Pharmacy

Review Note/Tracking of Compliance – 7/16/09

Qtrly Rpt to Accreditation Cmte – 10/5/09

Action Plan: All CLC residents medication regimen will be reviewed each month by a pharmacist beginning 7/2009. This medication review must be documented in the monthly pharmacy review note. The Pharmacy Manager will monitor compliance by the CLC Pharmacist and unit. The Pharmacy Manager will include tracking and trending results in the Medication Management quarterly report to the Accreditation Care Planning Sub-Committee beginning with 7/2009 reviews. The first committee report will be presented on 10/5/2009.

Recommendation 9. We recommended that the VISN Director ensure that the System Director requires that MRI screening forms be accessible timely in CPRS and that the forms contain complete patient identification information.

Concur   **Target Completion Date**: 9/15/2009

Action Plan: The Radiology Manager will meet with the Clinical Applications Coordinator to investigate/develop the capability of IMED system to incorporate the MRI safety questionnaire into the system. If IMED system is unable to include MRI safety questionnaire Information Systems (IS) will need to provide signature pads and supporting software.

OIG Contact and Staff Acknowledgments

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