Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 09-01732-10

Combined Assessment Program Review of the James E. Van Zandt VA Medical Center Altoona, Pennsylvania

October 16, 2009

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 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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Executive Summary

Introduction

During the week of June 22–26, 2009, the OIG conducted a Combined Assessment Program (CAP) review of the James E. Van Zandt VA Medical Center (the medical center), Altoona, PA. 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 to 59 medical center employees. The medical center is part of Veterans Integrated Service Network (VISN) 4.

Results of the Review

The CAP review covered seven operational activities. We identified the following organizational strength:

- *Methicillin-Resistant Staphylococcus Aureus* (MSRA) Prevention Program.

We made recommendations in four of the activities reviewed. For these activities, the medical center needed to:

- Review housekeeper staffing methodologies to ensure compliance with emergency department (ED) cleanliness standards.
- Require inter-facility transfer documentation to comply with Veterans Health Administration (VHA) policy.
- Ensure that nurse competencies for point-of-care (POC) testing are kept current.
- Require transportation service drivers to obtain required training and to comply with local and VHA training and documentation policies.
- Ensure that all utility room doors are locked.
- Require signage to comply with VHA policy and to facilitate access to health care.
- Ensure that environment of care (EOC) rounds are consistently attended by required team members and that all EOC rounds information is documented.
- Develop and implement a local policy for monitoring, maintaining, and testing the electronic patient elopement detection system.
- Require nursing staff to document pain medication effectiveness in the timeframe specified by local policy.

- Formally notify providers who receive a Level II or III peer review of their opportunity to submit comments to the Peer Review Committee (PRC) and ensure comments submitted by a provider are reviewed by the full PRC.
- Ensure that contract physicians' privileges do not extend beyond the length of the contract.

The system complied with selected standards in the following three activities:

- Coordination of Care.
- Patient Satisfaction.
- Suicide Prevention.

This report was prepared under the direction of Randall Snow, JD, Associate Director, Washington, DC, Office of Healthcare Inspections.

Comments

The VISN and Medical Center Directors agreed with the CAP review findings and recommendations and submitted acceptable improvement plans. (See Appendixes A and B, pages 15–21, for the full text of the Directors' comments.) We will follow up on the planned actions until they are completed.

(original signed by Julie Watrous,
CAP Group Director for:)

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

Introduction

Profile

Organization. The medical center is a general medical, surgical, and long-term care facility located in Altoona, PA, that provides a broad range of inpatient and outpatient health care services. Outpatient care is also provided at three community based outpatient clinics (CBOCs) in Johnstown, State College, and DuBois, PA. The medical center is part of VISN 4 and serves a veteran population of more than 85,900 throughout 14 counties in central Pennsylvania.

Programs. The medical center provides inpatient acute care, long-term care, and outpatient services. It has 28 hospital beds and 40 community living center (CLC)[1] beds.

Resources. In fiscal year (FY) 2008, medical care expenditures totaled approximately $96.2 million. The FY 2009 medical care budget was more than $96.1 million. FY 2008 staffing was 536 full-time employee equivalents (FTE), including 30 physician and 120 nursing FTE.

Workload. In FY 2008, the medical center treated 24,325 unique patients and provided 4,691 inpatient days in the hospital and 9,416 inpatient days in the CLC. The inpatient care workload totaled 930 discharges, and the average daily census, including CLC patients, was 38.5. Outpatient workload totaled 154,678 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

[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.

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 seven activities:

- Coordination of Care.
- Emergency/Urgent Care Operations.
- EOC.
- Medication Management.
- Patient Satisfaction.
- QM.
- Suicide Prevention.

The review covered medical center operations for FY 2008 and FY 2009 through June 22, 2009, and was done in accordance with OIG standard operating procedures for CAP reviews. We followed up on selected recommendations from our prior CAP review of the medical center (*Combined Assessment Program Review of the James E. Van Zandt VA Medical Center, Altoona, Pennsylvania,* Report No. 06-00008-130, April 17, 2006). We found that the medical center had corrected all findings from our previous CAP review.

We also followed up on recommendations from a prior OIG inspection (*Assessment of Legionnaire's Disease Risk in Veterans Health Administration Inpatient Facilities*, Report No. 07-00029-151, June 20, 2007). The inspection surveyed inpatient facilities, including the medical center, for Legionnaire's disease (LD) prevention strategies. We found that the medical center has a written plan that addresses the prevention of LD and that the medical center is consistently performing monthly LD risk assessments. We consider the medical center to be in compliance with the recommendations.

During this review, we also presented fraud and integrity awareness briefings for 59 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 make recommendations for improvement. Recommendations pertain to issues that are significant enough to be monitored by the OIG until corrective actions are implemented. Activities in the "Review Activities Without Recommendations" section have no reportable findings.

Organizational Strength

Methicillin-Resistant Staphylococcus Aureus Prevention Program

The medical center uses volunteers to provide additional training for inpatients to prevent the spread of MSRA, which is a bacterium responsible for difficult to treat infections in humans. By using volunteers as hand hygiene role models, inpatients are more willing to wash their hands when leaving their rooms and their inpatient units. All volunteers receive initial and annual training on MSRA prevention. Patient escorts, recreational therapy volunteers, and others who have regular, direct contact with inpatients have been instrumental in assisting the medical center in reducing the spread of MSRA.

Results

Review Activities With Recommendations

Emergency/Urgent Care Operations

The purpose of this review was to evaluate selected aspects of the ED, such as clinical services, consultations, inter-facility transfers, staffing, and staff competencies.

We interviewed physicians, the ED program manager, and others. We reviewed policies and other pertinent documents, including competency files and credentialing and privileging folders. We reviewed the medical records of patients who received consults, were transferred to other medical facilities, or were admitted to inpatient units in the medical center. Our review showed that clinical services and consults were appropriate. We identified the following conditions that required management attention.

Staffing. The medical center is designated a Veterans Rural Access Hospital and has six operational beds in the ED. VHA staffing models generally require EDs to have a physician and at least two registered nurses and one support

staff during all hours of operation. The medical center staffing matrix required only one registered nurse.

In May 2009, the medical center was granted a waiver from VHA which permits the ED physician to provide in-house coverage in addition to ED coverage after normal operating hours. The waiver requires monitoring and reporting of all care provided by the physician outside of the ED. For instances when additional staff is needed in the ED, the medical center follows its standard operating procedure for the nurse of the day (NOD), which requires the NOD to provide care for ED patients as needed. We suggested that the medical center review the contingency plan to ensure that it meets current operating needs.

EOC. The ED does not have a dedicated housekeeper aide. The aide assigned to the ED is responsible for the entire first floor of the medical center. This staffing methodology does not allow for compliance with acceptable cleanliness standards.

Transfer Documentation. We reviewed the medical records of three patients transferred from the ED to other medical facilities for care. Transfer documentation did not comply with VHA policy,[2] which requires the use of VA Form 10-2649A, "Inter-Facility Transfer Form," and/or the appropriate electronic medical record template note.

Nurse Competencies. We reviewed nurse competency documentation for completeness and found that for (POC) testing, only two of the three nurses' competencies were current.

Recommendation 1 We recommended that the VISN Director ensure that the Medical Center Director requires a review of housekeeper staffing methodologies to ensure compliance with ED cleanliness standards.

The VISN and Medical Center Directors concurred with the finding and recommendation. The Environmental Program Services Staffing Guide has been reviewed, and medical center managers concluded that the appropriate amount of time is being dedicated to cleaning the ED. The Environmental Management Service supervisor will monitor to ensure that a clean environment is maintained. The

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

implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

Recommendation 2 We recommended that the VISN Director ensure that the Medical Center Director requires that all inter-facility transfer documentation complies with VHA policy.

The VISN and Medical Center Directors concurred with the finding and recommendation. All providers will be reminded of VHA policy requirements. Health Information Management Service will monitor compliance and report findings to the Medical Records Committee. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

Recommendation 3 We recommended that the VISN Director ensure that the Medical Center Director requires that nurse competencies for POC testing are kept current.

The VISN and Medical Center Directors concurred with the finding and recommendation and will ensure that a system is in place to validate nurse competencies. The implementation plan is acceptable, and we will follow up on the planned action until it is completed.

Environment of Care

The purpose of this review was to determine whether the medical center maintained a clean, safe, and secure health care environment. Medical centers are required to provide a comprehensive EOC program that fully meets VHA, Occupational Safety and Health Administration, and external accreditation standards.

We inspected the CLC, the intensive care unit, the post-anesthesia care unit, the operating room, the fourth floor medical unit, primary care clinics, and the behavioral health clinic. Overall, we found the areas we inspected to be clean and well maintained. Managers who had housekeeping aides assigned to their areas expressed satisfaction with the working relationship. We identified the following conditions that required management attention.

Transportation Program. The medical center primarily provides transportation services to veterans in need of medical care at the VA Pittsburgh Healthcare System. VA drivers are responsible for the safe transportation of the

veterans and family members who utilize the transportation program.

Staff reported that: (a) veterans who needed return trip transportation were reluctant to disclose if they felt unwell, (b) clinicians were not always aware of or involved in the decision for appropriate return transportation, and (c) drivers were reluctant to decline a veteran's return transportation need as they realized the veteran had limited options. Some medical incidents have occurred that have necessitated calling 911 or resulted in reports to medical center management. A risk assessment with driver input has been accomplished, and an action plan has been developed.

We reviewed the transportation program and found that of the six drivers:

- Three do not have documentation of cardiopulmonary resuscitation (CPR) training.
- Only one has current CPR certification.
- Three do not have documentation of automated external defibrillator (AED) training; three have documentation of AED training in 2002, which is now expired.
- Only one has verification of his/her driving record.

Utility Rooms. Utility rooms throughout the medical center need to be secured (locked) to protect unauthorized persons from possible exposure to cleaning products or hazardous waste. We found that utility rooms were locked on several units, but they were not consistently locked throughout the medical center.

Signage. Standardized nomenclature is needed to ensure that patients seeking emergency care in any VHA facility can readily identify the appropriate location for such services. VHA policy[3] directs that any department providing emergency services be designated as an ED and that all signage directing patients to this location display "Emergency Department." There is no signage outside the medical center directing patients where to seek emergency services.

EOC Rounds. The purpose of EOC rounds is to continuously assess the medical center's environment for

[3] VHA Directive 2006-051, *Standards for Nomenclature and Operations in VHA Facility Emergency Departments*, September 15, 2006.

functionality, safety, and cleanliness for patients, staff, and visitors. EOC rounds should be performed on a weekly basis and include the disciplines outlined in VA and local policy. The medical center's EOC rounds team is led by the Associate Director, and membership includes the disciplines outlined in VA and local policy. However, we found that documentation of the frequency of and attendance on rounds was inconsistent.

Patient Elopement. Although we found that the CLC utilizes an electronic patient elopement detection system for patients at risk for wandering, there is no local policy that defines the procedures for monitoring and maintaining the system. Also, there was no documentation to support that the elopement system is routinely tested.

Recommendation 4 We recommended that the VISN Director ensure that the Medical Center Director requires that drivers who provide transportation services obtain required training and comply with local and VHA training and documentation policies.

The VISN and Medical Center Directors concurred with the findings and recommendation and will require that all bus drivers take CPR training. All drivers will be required to provide driving record verification. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

Recommendation 5 We recommended that the VISN Director ensure that the Medical Center Director requires that all utility room doors are locked.

The VISN and Medical Center Directors concurred with the finding and recommendation and will ensure that utility room doors are equipped with locking hardware. The implementation plan is acceptable, and we will follow up on the planned action until it is completed.

Recommendation 6 We recommended that the VISN Director ensure that the Medical Center Director requires that signage complies with VHA policy and facilitates patients' and visitors' access to health care.

The VISN and Medical Center Directors concurred with the finding and recommendation and will ensure that appropriate signage is installed. The implementation plan is acceptable,

and we will follow up on the planned action until it is completed.

Recommendation 7 We recommended that the VISN Director ensure that the Medical Center Director requires that EOC rounds are consistently attended by required team members and that all EOC rounds information is documented.

The VISN and Medical Center Directors concurred with the finding and recommendation. EOC rounds attendance is now being documented on a spreadsheet, and all EOC rounds inspections have a knowledgeable employee covering each area of expertise. Findings are documented, communicated to the affected service, and reported to the EOC Committee. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

Recommendation 8 We recommended that the VISN Director ensure that the Medical Center Director requires that staff develop and implement a local policy for monitoring, maintaining, and testing the electronic patient elopement detection system.

The VISN and Medical Center Directors concurred with the findings and recommendation. The local policy will be updated to include use, maintenance, and testing of the elopement system. Nursing staff will be educated. The system will be tested each shift, and maintenance checks will be performed. 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 adequate medication management practices. A safe medication management system includes medication ordering, administering, and monitoring.

We reviewed selected medication management processes in the inpatient medical and surgical units and in the intensive care unit. We found adequate management of medications brought into the facility by patients or their families. Nurses appropriately scanned patient armbands and used personal identifiers prior to medication administration. We interviewed patients and specifically questioned them on the medication administration process; all were able to cite key elements of

the patient identification process. We identified the following condition that required management attention.

Medication Effectiveness Documentation. We reviewed the Bar Code Medication Administration records of 15 patients who were hospitalized in selected units at the time of our visit. For each patient, we reviewed documentation for several doses of pain medication for a total of 88 doses. We found that nurses only documented pain medication effectiveness within the local policy's required timeframe of 2 hours for 60 (68 percent) doses.

Recommendation 9 We recommended that the VISN Director ensure that the Medical Center Director requires that nursing staff document pain medication effectiveness in the timeframe specified by local policy.

The VISN and Medical Center Directors concurred with the finding and recommendation. Nursing staff will be educated on pain medication effectiveness documentation. Compliance will be monitored, and reports will be presented to the Patient Care Services Management Council. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

Quality Management

The purpose of this review was to evaluate whether the medical center's QM program provided comprehensive oversight of the quality of care and whether senior managers actively supported the program's activities. We interviewed the medical center's Director and Chief of Staff, and we interviewed QM personnel. We evaluated plans, policies, performance improvement data, and other relevant documents.

The medical center's QM program was generally effective, and senior managers supported the program through participation in and evaluation of performance improvement initiatives and through allocation of resources to the program. Meaningful data were analyzed, trended, and utilized to improve patient care. Appropriate review structures were in place for 12 out of the 14 program activities reviewed. However, we identified the following two areas that needed improvement.

Peer Review. VHA regulations[4] require that providers whose cases are assigned a Level II or III[5] peer review during the initial peer review process be notified and invited to submit written comments on their case during initial review. Providers whose cases are assigned a Level II or III peer review after an initial review must be notified and invited to address the PRC in person or in writing. We reviewed all Level II and III peer reviews performed from October 1, 2008, to June 1, 2009, and found only two instances where a provider had submitted written comments. Also, we did not find consistent documentation in committee minutes or in the individual peer reviews that the individual whose care was under review was invited to provide comments for the initial review or the committee review.

In addition, when a provider does submit comments, VHA regulations require that the PRC review those comments. We found that when comments were submitted, they were reviewed by the service chief. The service chief then decided whether the peer review level assigned would remain the same or be changed.

Credentialing and Privileging. VHA regulations[6] require that clinical privileges granted to contractors do not extend beyond the contract period. Each new contract period requires reappraisal and reprivileging. We reviewed privileging documentation for five contract physicians. All five had privileges that extended beyond the contract period.

Recommendation 10 We recommended that the VISN Director ensure that the Medical Center Director requires that the Chairman of the PRC formally notify providers who receive a Level II or III peer review in writing of their opportunity to submit comments on their case to the PRC and that when comments are submitted by a provider, they are reviewed by the full PRC.

The VISN and Medical Center Directors concurred with the findings and recommendation. A standard memorandum has been developed to notify providers of their opportunity to submit comments to the PRC. All comments will be reviewed by the full PRC. The implementation plans are

[4] VHA Directive 2008-004, *Peer Review for Quality Management*, January 28, 2008.
[5] Level I – Most experienced, competent practitioners would have managed the case in a similar manner. Level II – Most experienced, competent practitioners might have managed the case differently. Level III – Most experienced, competent practitioners would have managed the case differently.
[6] VHA Handbook 1100.19, *Credentialing and Privileging*, November 14, 2008.

acceptable, and we will follow up on the planned actions until they are completed.

Recommendation 11 We recommended that the VISN Director ensure that the Medical Center Director requires that contract physicians' privileges do not extend beyond the length of the contract.

The VISN and Medical Center Directors concurred with the finding and recommendation. The identified providers have been privileged in accordance with the terms of their contracts. A system has been developed to ensure compliance. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

Review Activities Without Recommendations

Coordination of Care

The purpose of this review was to evaluate whether inpatient consultations, intra-facility (ward-to-ward) transfers, and discharges were coordinated appropriately over the continuum of care and met VHA and Joint Commission requirements. Coordinated consultations, transfers, and discharges are essential to an integrated, ongoing care process and optimal patient outcomes.

We reviewed the medical records of 10 inpatients who had consults ordered and performed internally. In general, we found that inpatients received consultative services within acceptable timeframes.

We determined that clinicians appropriately managed all 10 intra-facility transfers. We found transfer notes from sending to receiving units and documentation that nursing assessments were performed by the receiving units in accordance with established timeframes.

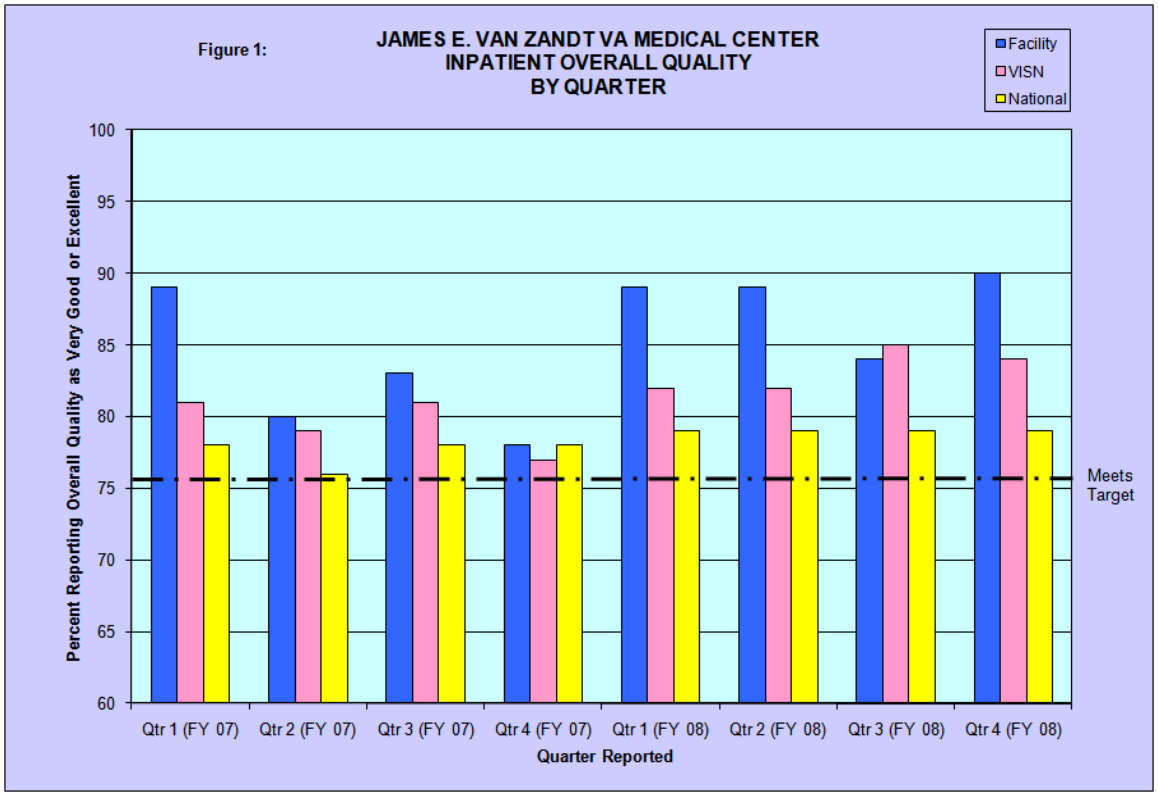
We reviewed the medical records of 10 discharged patients and found that all patients received appropriate written discharge instructions. We also found documentation that the patients understood the instructions. We made no recommendations.

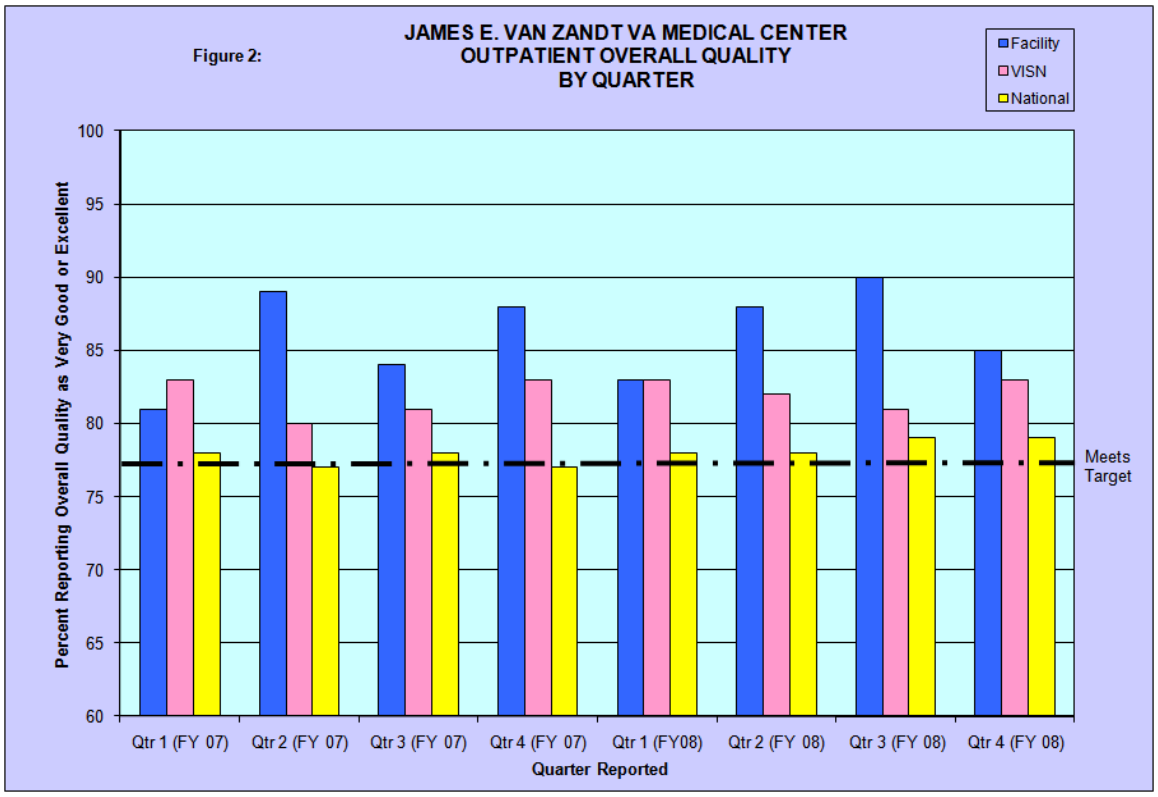
Patient Satisfaction

The purpose of this review was to assess the extent that VHA medical centers used quarterly survey results of patients' health care experiences with the VHA system to improve patient care, treatment, and services. The Performance Analysis Center for Excellence of the Office of Quality and Performance within VHA is the analytical, methodological, and reporting staff for the Survey of Healthcare Experiences of Patients (SHEP). VHA set performance measure goals for patients reporting overall satisfaction of "very good" or "excellent" at 76 percent for inpatients and 77 percent for outpatients. Medical centers are expected to address areas that fall below target scores.

We reviewed the inpatient and outpatient survey results for each quarter, beginning with the 1st quarter of FY 2007 and ending with the 4th quarter of FY 2008. Figures 1 and 2 on the next page show the medical center's SHEP performance measure results for inpatients and outpatients, respectively.

The medical center's inpatient results met or exceeded the target in all 8 quarters reviewed. The medical center's outpatient results exceeded the target in all 8 quarters reviewed. SHEP information is shared with staff and patients by the use of tri-folds, bulletin boards, and newsletters. This information is also shared with local veteran service organizations. The culture of customer service is demonstrated by the medical center consistently ranking high nationally and in the VISN. Though not included in this review, it is noteworthy that the medical center led the Nation in inpatient overall quality in February 2009 with a 96 percent satisfaction rate. We made no recommendations.





Suicide Prevention

The purpose of this review was to determine whether VHA health care facilities had implemented a suicide prevention program that was in compliance with VHA regulations. We assessed whether senior managers had appointed Suicide Prevention Coordinators (SPCs) at facilities and very large CBOCs,[7] and we evaluated whether SPCs fulfilled all required functions. Also, we verified whether medical records of patients determined to be at high risk for suicide contained Category II Patient Record Flags (PRFs),[8] documented safety plans that addressed suicidality, and documented collaboration between mental health (MH) providers and SPCs.

We interviewed the medical center SPC and MH providers, and we reviewed pertinent policies and the medical records of 9 patients determined to be at risk for suicide. We found that senior managers had appropriately appointed the SPC and that the SPC fulfilled the required functions. We found that documentation was complete in all medical records reviewed.

We also found that the SPC was actively involved in community MH outreach by coordinating VA activities with public MH systems and by maintaining awareness of community-based public and private MH assets, particularly with respect to veterans and their families. We made no recommendations.

[7] Very large CBOCs are defined as clinics with more than 10,000 unique patients enrolled.
[8] A Category II PRF is an alert mechanism that is displayed prominently in medical records.

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: September 18, 2009

From: VISN Director

Subject: **Combined Assessment Program Review of the James E. Van Zandt VA Medical Center, Altoona, PA**

To: Director, Washington, DC, Healthcare Inspections Division (54DC)

Director, Management Review Service (10B5)

I have reviewed the response to the OIG recommendations made by the Altoona VA Medical Center and concur with all actions. We appreciate the opportunity for review of our processes at the medical center.

(original signed by:)
MICHAEL E. MORELAND, FACHE
Network Director

Medical Center Director Comments

Department of Veterans Affairs **Memorandum**

Date: September 18, 2009

From: Medical Center Director

Subject: **Combined Assessment Program Review of the James E. Van Zandt VA Medical Center, Altoona, PA**

To: Network Director, VA Stars and Stripes Healthcare Network (10N4)

Attached are responses to the draft OIG CAP report from the survey conducted at James E. Van Zandt Medical Center, Altoona, Pennsylvania, from June 22–26, 2009.

(original signed by:)
TONY L. BENNETT, FACHE
Medical Center Director

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:

OIG Recommendations

Recommendation 1. We recommended that the VISN Director ensure that the Medical Center Director requires a review of housekeeper staffing methodologies to ensure compliance with ED cleanliness standards.

Concur with this recommendation.

Action Plan: The Environmental Program Services Staffing Guide dated October 2006 has been reviewed for compliance with Emergency Department cleanliness standards. Based on the staffing guide, a minimum of two hours is required to clean this area to standards. We currently dedicate three hours to the ED area; however, the EMS supervisor will monitor and ensure appropriate cleaning methods are being used to ensure a clean environment exists in this area.

Completion Date: 7/14/09

Recommendation 2. We recommended that the VISN Director ensure that the Medical Center Director requires that all inter-facility transfer documentation complies with VHA policy.

Concur with this recommendation.

Action Plan: All providers will be reminded of the requirements set forth in VHA Directive 2007-015, and Health Information Management Service will monitor compliance and report their findings through the Medical Records Committee. The monitor will be implemented as part of the FY 2010 Medical Records Review Plan.

Targeted Completion Date: 8/31/09.

Recommendation 3. We recommended that the VISN Director ensure that the Medical Center Director requires that nurse competencies for POC testing are kept current.

Concur with this recommendation.

Action Plan: The Associate Director for Patient/Nursing Service will ensure that a system is in place to validate that nurse competencies are current and in compliance with medical center policy.

Targeted Completion Date: 8/31/09

Recommendation 4. We recommended that the VISN Director ensure that the Medical Center Director requires that drivers who provide transportation services obtain required training and comply with local and VHA training and documentation policies

Concur with this recommendation.

Action Plan: All of the bus drivers will take CPR training. Verification of driving record will be obtained for all drivers.

Targeted Completion Date: 11/1/09

Recommendation 5. We recommended that the VISN Director ensure that the Medical Center Director requires that all utility room doors are locked.

Concur with his recommendation.

Action Plan: The door hardware on the Utility Rooms will be changed to locking hardware to secure these rooms.

Target Completion Date: 11/1/09

Recommendation 6. We recommended that the VISN Director ensure that the Medical Center Director requires that signage complies with VHA policy and facilitates patients' and visitors' access to health care.

Concur with this recommendation.

Action Plan: Emergency sign will be installed at the entrance.

Target Completion Date: 11/1/09

Recommendation 7. We recommended that the VISN Director ensure that the Medical Center Director requires that EOC rounds are consistently attended by required team members and that all EOC rounds information is documented.

Concur with this recommendation.

Action Plan: Documentation of attendance was changed. A spread sheet is now utilized for attendance. Practice has changed such that each area of expertise is covered by a knowledgeable employee for each inspection. The findings of each inspection is documented, communicated to affected service, solutions and corrections reported back to the safety office, and status of findings reported to the EOC committee.

Completion Date: 7/1/09

Recommendation 8. We recommended that the VISN Director ensure that the Medical Center Director requires that staff develop and implement a local policy for monitoring, maintaining, and testing the electronic patient elopement detection system.

Concur with this recommendation.

Action Plan:

1. Patient/Nursing Services' SOP 12 R-09 Patient Safety will be updated to include the use of the Elopement Risk Assessment. The manufacturer's guidelines for testing and use will be added as an attachment to this SOP, which will address how the patient wandering system is utilized and maintained.

Targeted Completion Date: 9/30/2009

2. The patient wandering system will be tested every shift, and the results of the test will be documented on the Patient Wandering Alarm System Test Flow Sheet.

Targeted Completion Date: 9/30/2009

3. Nursing staff will be educated on the revisions to SOP 12 R-09 Patient Safety related to the patient wandering system and how to test, document, and troubleshoot the system.

Targeted Completion Date: 9/30/2009

4. Facilities Service will continue to conduct quarterly maintenance checks of the patient wandering system as part of the preventative maintenance program.

Completion Date: 7/14/2009

Recommendation 9. We recommended that the VISN Director ensure that the Medical Center Director requires that nursing staff document pain medication effectiveness in the timeframe specified by local policy.

Concur with this recommendation.

Action Plan:

1. Nursing staff will be educated on the SOC A-22, Care of the Patient with Pain, to include documentation of PRN (as needed) effectiveness

within two (2) hours and documentation of a numerical pain score for effectiveness of pain medications.

Targeted Completion Date: 7/31/2009

2. The RN, nurse manager, and nursing officer of the day (NOD) will monitor the Medication Variance Log on each shift for timely documentation and numerical pain score related to PRN effectiveness.

Targeted Completion Date: 7/31/2009

3. The nurse manager will provide two (2) Plan Do Check Act (PDCA) forms:

PRN effectiveness within two (2) hours

Numerical pain score for effectiveness of pain medications

These PDCA forms will be presented monthly to Patient Care Services Management Council – Performance Improvement with the first report being due on 09/15/2009. Monitoring will be conducted for a six (6) month period with a threshold of 95% compliance.

Targeted Completion Date: 9/15/209

Recommendation 10. We recommended that the VISN Director ensure that the Medical Center Director requires that the Chairman of the PRC formally notify providers who receive a Level II or III peer review in writing of their opportunity to submit comments on their case to the PRC and that when comments are submitted by a provider, they are reviewed by the full PRC.

Concur with this recommendation.

Action Plan: Standard memo being sent by the Chair of Peer Review Committee (PRC) to formally notify providers, who receive a level II or III peer review in writing of their opportunity to submit comments on their case to PRC. Comments submitted by the provider are reviewed by the full PRC.

Completion Date: 7/13/09

Recommendation 11. We recommended that the VISN Director ensure that the Medical Center Director requires that contract physicians' privileges do not extend beyond the length of the contract.

Concur with this recommendation.

Action Plan: The identified physicians have been re-credentialed and privileged. The Credentialing and Privileging Coordinator will ensure that all contract physicians' privileges end on the same date as the contract ends. Credentialing and Privileging will coordinate with contracting official to ensure compliance. An internal monitoring spreadsheet has been initiated to ensure continued compliance.

Completion Date: 7/7/09

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