Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 08-03087-20

Combined Assessment Program Review of the Huntington VA Medical Center Huntington, West Virginia

November 5, 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 August 3–7, 2009, the OIG conducted a Combined Assessment Program (CAP) review of the Huntington VA Medical Center (the medical center), Huntington, WV. 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 258 medical center employees. The medical center is part of Veterans Integrated Service Network (VISN) 9.

Results of the Review

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

- Environmental Impact Actions.

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

- The Performance Improvement (PI) Council (PIC) meeting minutes reflect that recommended actions from committees for which they have oversight responsibility are tracked to completion.
- Contract physicians' privileges do not extend beyond the term of the contract.
- Mortality data is trended and analyzed, as required by Veterans Health Administration (VHA) policy.
- Peer Review Committee (PRC) minutes reflect the rationale for changes to initial peer review findings.
- Medical center policy designates which positions require Basic Life Support (BLS) and/or Advanced Cardiac Life Support (ACLS) certification and that an effective tracking system to monitor compliance is implemented.
- The privileging process complies with VHA regulations.
- Intra-facility nursing transfer notes are completed in accordance with medical center policy.
- A respiratory hygiene/cough etiquette program is implemented.

The medical center complied with selected standards in the following activity:

- Medication Management.

This report was prepared under the direction of Carol Torczon, Associate Director, St. Petersburg 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 13–19, for the 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 medical center is located in Huntington, WV, and provides a broad range of inpatient and outpatient health care services. Outpatient care is also provided at four community based outpatient clinics. The two located in Prestonsburg, KY, and Charleston, WV, are VA-staffed clinics, and the two located in Williamson and Logan, WV, are contract clinics. The medical center is part of VISN 9 and serves a veteran population of about 89,000 throughout 24 counties in West Virginia, Kentucky, and Ohio.

Programs. The medical center has 80 hospital beds for medical and surgical inpatient care. Outpatient services include primary, specialty, and mental health care as well as traumatic brain injury support.

Affiliations and Research. The medical center is affiliated with the Joan C. Edwards School of Medicine at Marshall University and provides training for 27 residents. In addition, the medical center has 32 other affiliated training programs in 21 health care fields. In fiscal year (FY) 2008, the medical center research program had 23 active research protocols and a budget of $153,000.

Resources. In FY 2008, medical care expenditures totaled approximately $175 million. The FY 2009 medical care budget was about $179 million. FY 2008 staffing was 1,039 full-time employee equivalents (FTE), including 73 physician and 268 nursing FTE.

Workload. In FY 2008, the medical center treated 29,487 unique patients and provided 20,566 inpatient days in the hospital. The inpatient care workload totaled 4,203 discharges, and the average daily census was 56.9. Outpatient workload totaled 293,623 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 five activities:

- Coordination of Care.
- Environment of Care (EOC).
- Medication Management.
- Physician Credentialing and Privileging (C&P).
- QM.

The review covered medical center operations for FY 2008 and FY 2009 through August 3, 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 of the medical center (*Combined Assessment Program Review of the VA Medical Center, Huntington, West Virginia,* Report No. 05-03281-168, July 17, 2006). The medical center had corrected all findings related to health care from our prior CAP review.

During this review, we also presented fraud and integrity awareness briefings to 258 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 findings requiring corrective action.

Organizational Strength

Environmental Impact Actions

The medical center has received two Environmental Excellence Awards from Hospitals for a Healthy Environment (H2E) and was a three-time Partner for Change Award winner. H2E awards recognize outstanding effort in environmental improvement. The Partner for Change Award recognizes health care facilities that continuously improve and expand upon mercury elimination, waste reduction, and pollution prevention programs.

In FY 2009, the medical center showed a 56 percent increase in paper recycling, largely due to an onsite shredding contract. Also, internal efforts to control medical waste that must be incinerated (IMW) has resulted in an 80 percent reduction in IMW. IMW now accounts for less than 3 percent of total waste from the medical center.

Other eco-friendly activities instituted by the medical center include recycling wood pallets, eyeglasses, surgical instrument wraps, laboratory preservative agents, and hearing aids. In addition, the medical center installed a Neptune Waste Management System in Surgery in 2009. This system collects surgical waste fluid within a totally closed system and then disposes of it with little human intervention, reducing operator exposure.

Results

Review Activities With Recommendations

Quality Management

The purposes of this review were to determine whether (a) the medical center had a comprehensive, effective QM program designed to monitor patient care activities and coordinate improvement efforts and (b) senior managers actively supported QM efforts and appropriately responded to QM results. To evaluate QM processes, we interviewed senior managers and reviewed the self-assessment completed by QM staff regarding compliance with QM requirements.

The QM program was generally effective in providing oversight of the medical center's quality of care, and senior managers supported the program. We noted compliance

with standards in nine areas. However, we identified the following five areas that needed improvement.

Monitoring of Recommended Actions. We found that PIC[1] meeting minutes did not reflect that actions recommended by committees for which the PIC has oversight responsibility were tracked to completion. Medical center policy requires monitoring of the progress of actions in meeting minutes.

C&P. We found that four of seven contract physicians were granted standard 2-year clinical privileges, which exceeded the length of the contracts. VHA policy[2] requires that clinical privileges granted to contract physicians do not extend beyond the contract period.

Mortality Trending and Analysis. We found that mortality reports did not include complete trending and analysis of data. VHA policy[3] requires collection and trending of provider-specific data and overall data analysis.

Peer Review. We found that PRC minutes did not reflect the rationale used to determine final peer review levels. PRC minutes from February 2 through July 14, 2009, documented 11 changes in peer review levels. In three cases, Level 2 reviews were increased to Level 3, and in eight cases, Level 2 or Level 3 reviews were decreased to Level 1.[4] The minutes reflected that providers submitted additional information and were invited to a discussion with committee members to aid in determining the final peer review levels. However, the minutes did not reflect the specifics of these discussions or the rationale for the final peer review level decisions. VHA policy[5] requires that changes made to initial peer review levels must be fully documented following discussion with the provider.

BLS and ACLS Certification. We found that not all staff required by VHA[6] and medical center policy to have BLS certification had documentation of current certification. We reviewed staff training records and found that

[1] The QM committee responsible for oversight of various medical staff committees.
[2] VHA Handbook 1100.19, *Credentialing and Privileging*, November 14, 2008.
[3] VHA Directive 2005-056, *Mortality Assessment*, December 1, 2005.
[4] Level 1 – Most experienced, competent practitioners would have managed the case in a similar manner;
Level 2 – Most experienced, competent practitioners might have managed the case differently; and
Level 3 – Most experienced, competent practitioners would have handled the case differently.
[5] VHA Directive 2008-004, *Peer Review for Quality Management*, January 28, 2008.
[6] VHA Directive 2008-008, *Cardiopulmonary Resuscitation (CPR) and Advanced Cardiac Life Support (ACLS) Training for Staff*, February 6, 2008.

6 (46 percent) of 13 police officers and 253 (94 percent) of 268 designated nursing staff had current BLS certifications. We were unable to determine if appropriate staff held current ACLS certifications due to the lack of a process to monitor training for timely completion. In addition, we found that medical center policy had not clearly designated which positions needed to maintain BLS and/or ACLS certification.

Recommendation 1 We recommended that the VISN Director ensure that the Medical Center Director requires that PIC meeting minutes reflect that recommended actions from committees for which the PIC has oversight responsibility are tracked to completion.

The VISN and Medical Center Directors concurred with the finding and recommendation. The medical center has four main councils, and all other committees and groups report to one of these councils. The Medical Staff Council uses a follow-up report to track action items from meetings to completion. The Leadership Council implemented this process following their May 2009 meeting. The PIC and Administrative Council will begin using this same process in October 2009. The four main councils will be responsible for continuing to track action items and reports from their assigned areas of oversight. The 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 contract physician privileges do not extend beyond the term of the contract.

The VISN and Medical Center Directors concurred with the finding and recommendation. Professional Standards Board (PSB) appointment forms have been revised to include the specific period of the appointment. Credentialing staff have been educated on form completion and documentation processes and have been instructed not to use a standard 2-year appointment for any contract staff. The corrective actions are acceptable, and we consider this recommendation closed.

Recommendation 3 We recommended that the VISN Director ensure that the Medical Center Director requires that mortality data is trended and analyzed, as required by VHA policy.

The VISN and Medical Center Directors concurred with the finding and recommendation. The medical center reviews and documents each inpatient mortality. A quarterly report is presented to the PIC, the Leadership Council PI Subcommittee, and VISN 9. Trending of data will be added to the report, and data analysis will be expanded. Adverse trends will be noted, provider-specific data will continue to be reviewed, and any outlier data will be reported through the PRC. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

Recommendation 4 We recommended that the VISN Director ensure that the Medical Center Director requires that PRC minutes reflect the rationale for changes to initial peer review findings.

The VISN and Medical Center Directors concurred with the findings and recommendation. PRC meeting minutes will describe the committee members' final vote for the determination of peer review levels. In addition, PRC minutes will contain the rationale for any changes in initial peer review level determinations. The corrective actions are acceptable, and we consider this recommendation closed.

Recommendation 5 We recommended that the VISN Director ensure that the Medical Center Director requires that medical center policy designates which positions require BLS and/or ACLS certification and that an effective tracking system to monitor compliance is implemented.

The VISN and Medical Center Directors concurred with the findings and recommendation. Service chiefs have identified staff required to have BLS and/or ACLS certification. The Nursing Education Coordinator has been designated as the point of contact for BLS and ACLS training and will maintain centralized records. Documentation of completed training will be maintained. Each service with employees who require BLS or ACLS certification will select their own point of contact who will be responsible for tracking training dates and scheduling employees for training. Current medical center policy has been revised. A second medical center policy specific to staff requirements for BLS and ACLS is under development. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

Physician Credentialing and Privileging

The purpose of this review was to determine whether VHA facilities have consistent processes for the C&P of physicians. For a sample of physicians, we reviewed selected VHA required elements in C&P files and provider profiles.[7] We also reviewed meeting minutes during which discussions about the physicians took place.

We reviewed 10 physicians' C&P files and profiles. We found that licenses were current and that primary source verification had been obtained for all 10 physicians. A Focused Professional Practice Evaluation was appropriately implemented for the only physician hired within the past 12 months. However, we identified the following areas that needed improvement.

Privilege Forms. VHA regulations require privilege forms to contain current provider-specific information. We noted that some forms had incomplete information for service-specific designation and approval of specific privileges. Also, we found outdated performance reporting on 9 (90 percent) of the 10 privilege request forms.

Ongoing Professional Practice Evaluation. VHA regulations also require specific competency criteria for Ongoing Professional Practice Evaluation (OPPE) for all privileged physicians. We found that for the 2-year period prior to re-privileging, OPPE data for 8 of 9 physicians were not specific and did not support additional privileges granted. In addition, we found that PSB minutes did not contain service chief evaluation of OPPE data to ensure competency prior to recommending re-privileging.

Recommendation 6 We recommended that the VISN Director ensure that the Medical Center Director requires that the privileging process complies with VHA regulations.

The VISN and Medical Center Directors concurred with the findings and recommendation. An OPPE form was developed and submitted to the PSB for approval. The form includes a place for credentialing staff to verify that the form is complete, has been signed by the appropriate service chief, and documents the date of PSB review. An outcome analysis of provider-specific data and a signature block for the Chair of the PSB has also been included on the form. Credentialing staff will be responsible for documenting

[7] VHA Handbook 1100.19, *Credentialing and Privileging*, November 14, 2008.

review of OPPE in PSB minutes and will notify service chiefs to submit quality data for any provider being re-credentialed. The Risk Manager will conduct monthly reviews to ensure compliance. 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 the medical center's intra-facility transfers and discharges were coordinated appropriately over the continuum of care and met VHA and Joint Commission requirements. Coordinated transfers and discharges are essential to an integrated, ongoing care process and optimal patient outcomes.

We reviewed 10 medical records of discharged patients and found that 9 (90 percent) had appropriate documentation of discharge instructions and medications. One record did not include evidence that the patient/caregiver received a copy of the discharge instructions. We identified the following area that needed improvement.

Incomplete Transfer Documentation. The medical center had developed and implemented an "Intraward Transfer/Handoff" electronic medical record (EMR) documentation template for all intra-facility transfers. According to medical center policy, this is to be completed by a registered nurse (RN) on both the sending and receiving units. We reviewed 20 intra-facility transfers and found that only 12 (60 percent) of the EMR transfer notes contained all required elements. For example, eight (40 percent) of the notes did not have nursing assessments completed by the receiving unit RN at the time of transfer.

Recommendation 7 We recommended that the VISN Director ensure that the Medical Center Director requires that intra-facility nursing transfer notes are completed in accordance with medical center policy.

The VISN and Medical Center Directors concurred with the findings and recommendation. A spreadsheet that includes transferring and receiving unit information was developed and is populated daily. Medical records are being reviewed for compliance with policy. Nursing leaders are providing staff education and counseling, and documentation expectations have been clarified. Data will be aggregated monthly, and disciplinary action will be taken when necessary. 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 medical center maintained a safe and clean health care environment. VHA facilities are required to establish a comprehensive EOC program that fully meets VHA, National Center for Patient Safety, Occupational Safety and Health Administration, National Fire Protection Association, and Joint Commission standards.

We inspected the dialysis unit, the outpatient clinics, the medical/surgical intensive care unit (MICU/SICU), the telemetry unit, the acute inpatient medical/surgical unit, the dental clinic, the emergency department, the inpatient pharmacy, the inpatient laboratory, and the patient food preparation area. We found that the medical center maintained a generally clean and safe environment. The infection control program monitored, analyzed, and appropriately reported data to clinicians for PI. We also found that the fire and safety program conducted drills as required by safety standards and that there was consistent follow-up on drill critique issues, including reporting of findings to the EOC Committee.

During our inspection, we found a lack of visual privacy in the dialysis unit. While we were onsite, managers provided additional curtains. We also found that the mental health outpatient clinic checkout area lacked auditory privacy. Managers provided us with a copy of the contract for a construction project to reconfigure the mental health clinic area, which will correct the privacy deficiencies. Therefore, we made no recommendations for these findings.

Environmental and safety guidelines require that all chemicals be stored in a secured location when not in use. We found a housekeeping cart with unsecured chemicals left unattended on the acute inpatient medical/surgical unit. The cart was also blocking the fire exit door. Managers took action immediately, and an employee moved the cart to a safe area. We also found an unattended cart containing paint in the 2nd floor hallway of Building 1. An employee moved this cart to a safe area. In addition, we found unsecured chemicals in a non-lockable supply closet on the dialysis unit. A lock was placed on the door while we were onsite. As these safety issues were corrected immediately,

we made no recommendations. However, we identified the following area that needed improvement.

Infection Control. The Centers for Disease Control and Prevention requires the implementation of a respiratory hygiene/cough etiquette program in health care settings. This program is to provide on-the-spot patient and family education, accessible personal protective equipment, and hand sanitizer in all high traffic areas and at main entrances. We found that the medical center did not have such a program in place.

Recommendation 8 We recommended that the VISN Director ensure that the Medical Center Director requires the implementation of a respiratory hygiene/cough etiquette program.

The VISN and Medical Center Directors concurred with the finding and recommendation. The Infection Control Practitioner is working with Acquisitions and Logistics staff to arrange for the purchase of respiratory hygiene stations. These stations will be placed in key locations throughout the medical center. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

Review Activities Without Recommendations

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 acute inpatient medical/surgical unit and on the MICU/SICU.

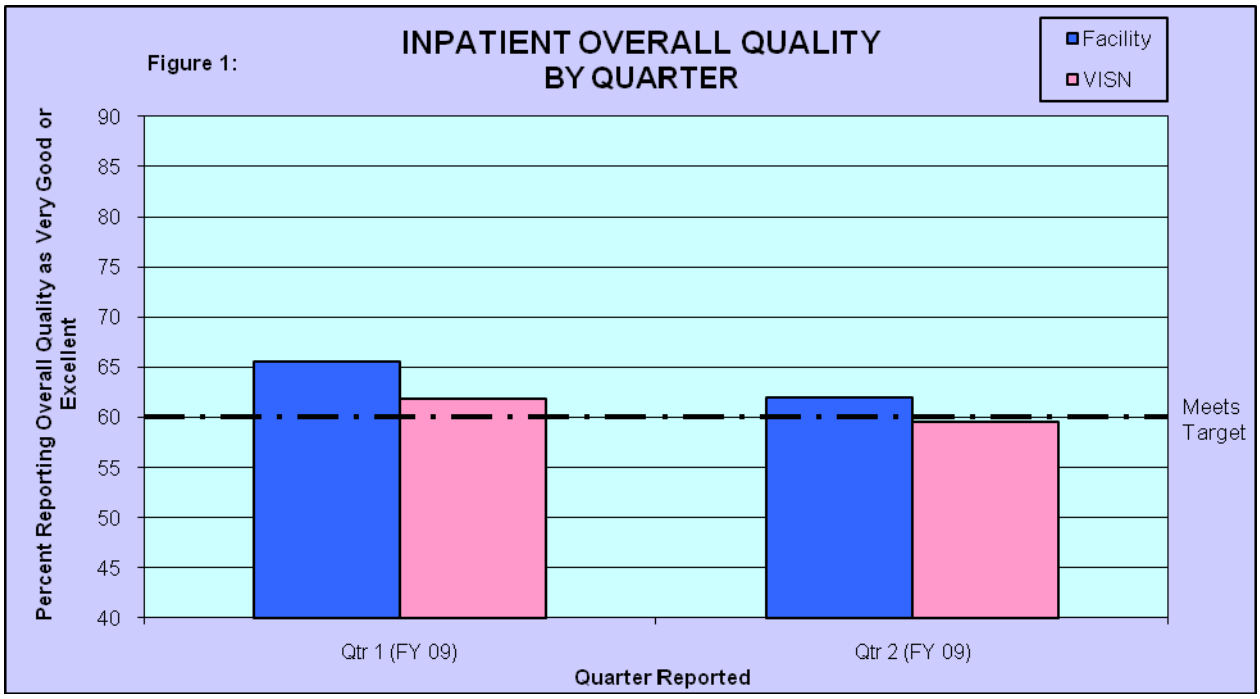
We found that the medical center had a designated Bar Code Medication Administration (BCMA) Program Coordinator who had appropriately identified and addressed medication administration problems. Medical center policy did not require a specified timeframe for nursing staff to document PRN (as needed) pain medication effectiveness. However, based on recommendations from senior management, the BCMA Coordinator had recently begun tracking and reporting documentation of pain medication effectiveness completed within 4 hours of administration. An action plan was in place to address variances.

We reviewed the medical records of 13 patients who received a total of 51 doses of PRN pain medication. We

found that 46 (90 percent) of 51 doses had documentation of PRN pain medication effectiveness and that 37 (80 percent) of the 46 doses had effectiveness documented within 4 hours. Since the medical center had already identified this as a PI opportunity and had developed an action plan, we made no recommendations.

VHA Satisfaction Surveys

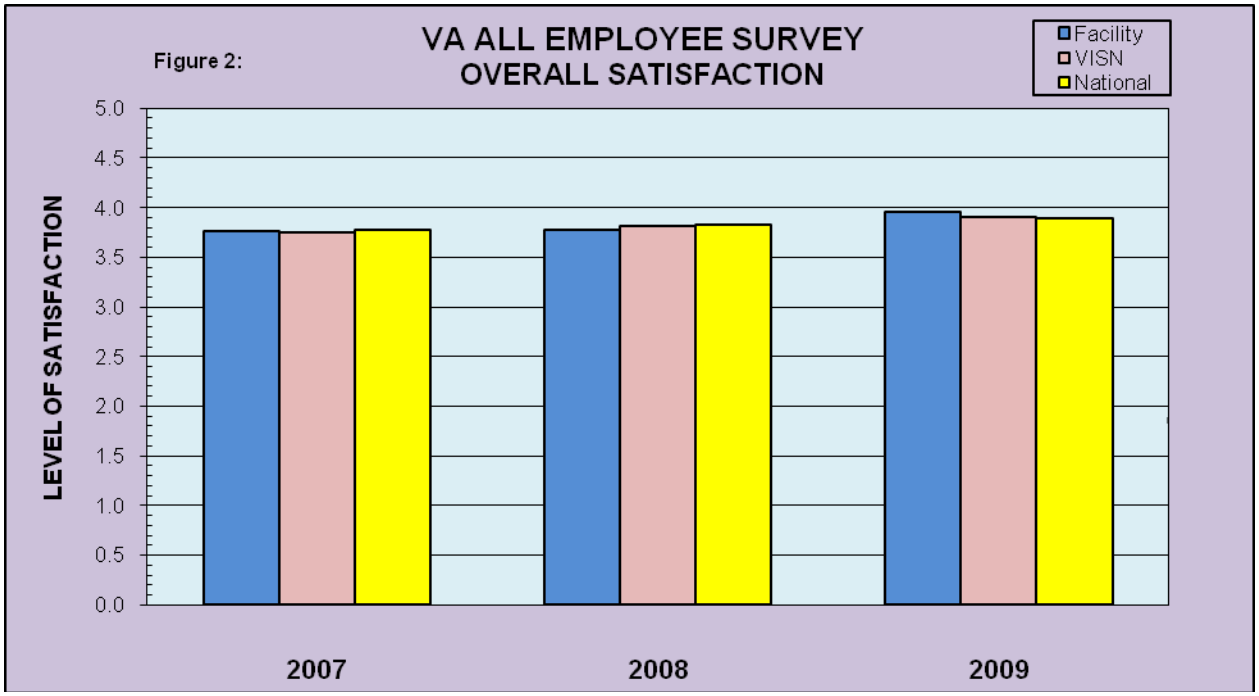
VHA has identified patient and employee satisfaction scores as significant indicators of facility performance. Patients are surveyed monthly, and data are summarized quarterly. Figure 1 below shows the medical center's and VISN's overall inpatient satisfaction scores for quarters 1 and 2 of FY 2009.[8] The target score is noted on the graph.



Employees are surveyed annually. Figure 2 on the next page shows the medical center'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.

[8] Due to technical difficulties with VHA's outpatient survey data, no outpatient satisfaction scores are available for quarters 1 and 2 of FY 2009.

Figure 2:


VA ALL EMPLOYEE SURVEY
OVERALL SATISFACTION
Facility
VISN
National
LEVEL OF SATISFACTION
5.0
4.5
4.0
3.5
3.0
2.5
2.0
1.5
1.0
0.5
0.0
2007
2008
2009

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: September 29, 2009

From: Director, VA Mid South Healthcare Network (10N9)

Subject: **Combined Assessment Program Review of the Huntington VA Medical Center, Huntington, West Virginia.**

To: Associate Director, St. Petersburg Office of Healthcare Inspections (54SP)

Director, Management Review Service (10B5)

1. I concur with the findings and recommendations of this Office of Inspector General Combined Assessment Program Review of the Huntington VA Medical Center, Huntington, West Virginia, as well as the action plan developed by the facility.

2. If you have questions or require additional information from the Network, please do not hesitate to contact Pamela Kelly, Staff Assistant to the Network Director at 615-695-2205 or me at 615-695-2206.

(original signed by:)
John Dandridge, Jr.

Appendix B

Medical Center Director Comments

Department of Veterans Affairs **Memorandum**

Date: **October 21, 2009**

From: Director, Huntington VA Medical Center (581/00)

Subject: **Combined Assessment Program Review of the Huntington VA Medical Center, Huntington, West Virginia.**

To: Director, VA Mid South Healthcare Network (10N9)

1. On behalf of the VA Medical Center Huntington, West Virginia, I want to express my appreciation to the Office of the Inspector General (OIG) Survey Team for their professional and comprehensive Combined Assessment Program (CAP) review conducted August 3 through August 7, 2009.

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

(original signed by:)
Edward H. Seiler

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 that PIC meeting minutes reflect that recommended actions from committees for which the PIC has oversight responsibility are tracked to completion.

Concur

Facility Response: There are four main Councils for the organization: The Leadership Council, the Administrative Council, the Medical Staff Council, and the Performance Improvement Council. All other organizational committees and functional groups report to one of these Councils. The Medical Staff Council uses a follow up report to track action items from the Council's meetings. The report was developed and implemented in January 2009. The report follows items until completion and is forwarded to the appropriate staff after each Council meeting. The Leadership Council implemented the process following the May 2009 meeting. The PI Council and Administrative Council will begin using the same process and report starting with their October meetings. The four main Councils will be responsible for continuing to track the reports from their assigned areas of oversight and will track action items as they are reported.

Recommendation 2. We recommended that the VISN Director ensure that the Medical Center Director requires that contract physician privileges do not extend beyond the term of the contract.

Concur

Facility Response: Appointment forms initiated by the Professional Standards Board have been revised to list the specific time frame of appointment (i.e., from _____ date to _____ date). Dates listed on the form are specific to the individual provider based on the status of the candidate and the length of appointment (i.e., locum tenens, full time provider, etc.). Credentialing staff have been educated on the process, including the appropriate completion of the forms and documentation in PSB minutes, and have been instructed not to use "standard two year appointment" for any contract staff. **Target for Completion**: Completed. A review of credentialing folders and the PSB minutes for

September 17, 2009 for recently credentialed or re-credentialed providers demonstrated compliance.

Recommendation 3. We recommended that the VISN Director ensure that the Medical Center Director requires that mortality data is trended and analyzed, as required by VHA policy.

Concur

Facility Response: VHA Directive 2005-056, Mortality Assessment, states "Trending of mortality data to identify suspicious events and trends is implemented. Deaths are to be trended by facility, ward, service line, shift time, and provider when a specific provider can be linked to the care of specific patients, i.e., attending physician." The facility reviews each inpatient mortality as stated in the Directive and documents each case on an Excel spreadsheet. A quarterly report is presented to the Performance Improvement Council and the Leadership Council Performance Improvement Subcommittee. The report includes the total number of deaths for the quarter; the number and percentage of deaths where Do Not Resuscitate (DNR) status was in place; the percentage of deaths by service; the number and percentage of deaths by shift; and the percentage of deaths by inpatient unit. Graphic representation of the data is provided for: Deaths by Code Status; Deaths per Service; Deaths by Shift; and Deaths per Ward. The report is also submitted to the Mid South Healthcare Network on a quarterly basis. For the 4th quarter FY09 report trending of inpatient deaths referred to peer review will be added to the report. In addition, analysis of the data presented will be expanded to include a comparison of the current quarter's data to previous quarters. Any adverse trends will also be noted. Provider specific data will continue to be reviewed and any outlier data reported through the Peer Review Committee. **Target Completion :** October 15, 2009**.**

Recommendation 4. We recommended that the VISN Director ensure that the Medical Center Director requires that PRC minutes reflect the rationale for changes to initial peer review findings.

Concur

Facility Response: The Peer Review Committee minutes have always documented changes in the determination of the final peer review level (i.e., level I, level II, or level III). These determinations have been based on Committee member review of the specific case, input as provided by the individual under review, and review of any available medical records. Beginning with the Peer Review Committee meeting of September 23, 2009, documentation has been placed in the committee meeting minutes to describe the final vote by committee members for each final determination of a level. In addition, any change in the final

level is accompanied by a description as to the rationale for the change from the initial peer review determination. The Peer Review/Risk Management Program Support Assistant has been instructed on the need to ensure that this documentation is in place in the minutes of each Peer Review Committee meeting. **Target Completion Date:** Completed.

Recommendation 5. We recommended that the VISN Director ensure that the Medical Center Director requires that medical center policy designates which positions require BLS and/or ACLS certification and that an effective tracking system to monitor compliance is implemented.

Concur

Facility Response:
1. Service Chiefs identified staff required to have BLS and/or ACLS the week of August 3, 2009 (completed).
2. The Nursing Education Coordinator has been designated as the facility point of contact for BLS and ACLS training and will maintain centralized records. The Chief, Learning Resources has been designated as the secondary facility point of contact. Documentation of completed training will be maintained in the TEMPO system (completed).
3. Each service that has employees who require BLS or ACLS certification will select a service employee point of contact. The service representative will be responsible for record keeping accountability for tracking training dates; scheduling employees in BLS/ACLS training classes; and notifying the service chief monthly starting at the 6 month mark prior to the certification expiration date.
4. Current Medical Center Memorandum (MCM) PCI-6: Cardiopulmonary Resuscitation (CPR) and the Code Blue Team has been reviewed and revised. A second MCM is under development specific to staff requirements for BLS and ACLS. The new MCM will be sent to the ICU Committee and the Medical Staff Council prior to forwarding to the Director for signature approval. **Target Completion Date:** November 20, 2009.

Recommendation 6. We recommended that the VISN Director ensure that the Medical Center Director requires that the privileging process complies with VHA regulations.

Concur

Facility Response: Ongoing Professional Practice Evaluation: A form for use in reviewing individual provider's Ongoing Professional Practice Evaluation was developed and submitted to the Professional Standards Board September 24, 2009, for approval. The form includes a place for Credentialing staff to verify that the OPPE form is complete and has been signed by the appropriate service chief. In addition, there is a space to

document the date of the PSB review, an outcome analysis of the data presented, and a signature block for the chairman of the PSB. The form will be placed in the individual providers credentialing folder after the PSB has reviewed the OPPE. OPPE will continue to be submitted to the PSB every six months for all appropriate staff. The Credentialing staff will be responsible for documenting review of the OPPE in the PSB minutes and will track on an Excel spreadsheet to ensure that OPPE has been reviewed as required. **Target Completion Date:** December 31, 2009.

Privilege Forms: The Credentialing staff will notify Service Chiefs weekly, for 3 weeks, in advance of the scheduled PSB to submit quality data for any provider being re-credentialed. The Credentialing staff will verify that all areas of the form have been completed as required. Deficient areas will be brought to the attention of the Chairman of the PSB for follow-up corrective actions. The Risk Manager will conduct a monthly review of all credentialed and re-credentialed providers for the timeframe of October 1, 2009 through December 31, 2009 to confirm compliance. **Target Completion Date:** December 31, 2009.

Recommendation 7. We recommended that the VISN Director ensure that the Medical Center Director requires that intra-facility nursing transfer notes are completed in accordance with medical center policy.

Concur

Facility Response: The following process has been initiated to improve compliance with the facility policy on Intraward Patient Transfers:

1. An Excel spreadsheet was developed to include both transferring unit and receiving unit information. This spreadsheet is populated daily and lists each inpatient transfer that occurred during the previous 24 hour period. The patient medical records are then reviewed for compliance with policy, and the information is entered into the spreadsheet. Nurse Leaders (i.e., Managers, Clinical Nurse Coordinators, or the Nursing Supervisors) are responsible for entering the data into the spreadsheet.
2. Staff education and counseling is provided by Nursing Leaders based on deficiencies noted on the daily review. Expectations for documentation include completion of the following:
    a. Intraward Transfer Note–to be completed by both transferring and receiving units.
    b. Physical Assessment Note to be completed at time of transfer by both transferring and receiving unit.
    c. Care Plan update by both units.
3. Disciplinary action will be taken based on continued staff noncompliance. Data will be aggregated monthly to identify whether or not actions have led to improvement. **Target Completion Date:** Process

has been implemented. The first aggregate performance improvement report will be completed by October 16, 2009.

Recommendation 8. We recommended that the VISN Director ensure that the Medical Center Director requires the implementation of a respiratory hygiene/cough etiquette program.

Concur

Facility Response: An ad hoc work group met and reviewed the respiratory hygiene stations that are available for purchase. Initially a product was selected; however, upon further review, the product was deemed unsuitable due to a lack of compatibility with our current alcohol-based hand cleaner. The Infection Control Practitioner is working with the staff of Acquisitions and Logistics to resolve the issue and to arrange purchase of the stations. Once the respiratory hygiene stations are purchased, they will be placed in key locations, including: the Emergency Department/Outpatient Laboratory waiting area; Surgery Clinic waiting area; Medical Specialty Clinic waiting area; Optometry Clinic waiting area; Outpatient Pharmacy waiting area; Mental Health waiting area; Canteen entrance; Green Team waiting area; Human Resource lobby entrance; and the 1st floor entrance by the Telephone Operators.
Target Completion Date: October 16, 2009.

OIG Contact and Staff Acknowledgments

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