Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 09-03532-112

Combined Assessment Program Review of the Cincinnati VA Medical Center Cincinnati, Ohio

March 19, 2010

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.

To Report Suspected Wrongdoing in VA Programs and Operations:
Telephone: 1-800-488-8244
E-Mail: vaoighotline@va.gov
(Hotline Information: **http://www4.va.gov/oig/contacts/hotline.asp**)

Table of Contents

Executive Summary

Introduction

During the week of November 30–December 3, 2009, the OIG conducted a Combined Assessment Program (CAP) review of the Cincinnati VA Medical Center, (the medical center) Cincinnati, OH. 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 166 medical center employees. The medical center is part of Veterans Integrated Service Network (VISN) 10.

Results of the Review

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

- Mobile Health Unit Outreach Initiative.
- Post-Traumatic Stress Disorder (PTSD) and Anxiety Disorders Program Women's Residential Rehabilitation Treatment Program (RRTP).

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

- Ensure that peer review data are reported to the Medical Executive Committee, as required by Veterans Health Administration (VHA) policy.
- Fully implement a comprehensive respiratory protection program.
- Address the identified mental health and infection control training deficiencies.
- Properly maintain negative air pressure room (NAPR) logs and ensure that staff are educated on their responsibilities.
- Require timely assessment and documentation of pain medication effectiveness and monitor data to ensure compliance with local policy.
- Ensure that monthly evaluations are completed and that clinical competencies are demonstrated and documented for contracted/agency registered nurses (RNs).

The medical center complied with selected standards in the following three activities:

- Coordination of Care.
- Magnetic Resonance Imaging (MRI) Safety.
- Physician Credentialing and Privileging.

This report was prepared under the direction of Randall Snow, 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 13–17, 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 a two-division (Cincinnati and Ft. Thomas, OH) tertiary referral facility that provides a broad range of inpatient and outpatient health care services. Outpatient care is also provided at six community based outpatient clinics in Clermont, Georgetown, and Hamilton, OH; Bellevue and Florence, KY; and Dearborn, IN. The medical center is part of VISN 10 and serves a veteran population of about 143,000 throughout 17 counties in Ohio, Kentucky, and Indiana.

Programs. The medical center provides comprehensive health care through primary care, specialty outpatient services, and tertiary care in the areas of medicine, surgery, psychiatry, physical medicine and rehabilitation, neurology, oncology, dentistry, and geriatrics. The medical center is also the VISN 10 referral site for neurosurgery. It has 133 hospital beds, 72 domiciliary beds, and 64 community living center (CLC) beds.

Affiliations and Research. The medical center is affiliated with the University of Cincinnati's College of Medicine and provides training for more than 400 residents as well as students in other disciplines, including nursing, psychology, and physical therapy. In fiscal year (FY) 2009, the medical center's research program had 200 projects and a budget of approximately $2.5 million. Important areas of research included PTSD, smoking cessation, and cardiology.

Resources. FY 2009 medical care expenditures totaled $232 million. The FY 2010 medical care budget is $250 million. FY 2009 staffing was 1,761.3 full-time employee equivalents (FTE), including 133.7 physician and 537.2 nursing FTE.

Workload. In FY 2009, the medical center treated 34,960 unique patients and provided 33,382 inpatient days in the hospital and 18,892 inpatient days in the CLC unit. The inpatient care workload totaled 6,153 discharges, and the average daily census, including CLC and domiciliary patients, was 198.7. Outpatient workload totaled 438,617 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 seven activities:

- Contracted/Agency RNs.
- Coordination of Care.
- Environment of Care (EOC).
- Medication Management.
- MRI Safety.
- Physician Credentialing and Privileging.
- QM.

The review covered medical center operations for FY 2008, FY 2009, and FY 2010 through December 4, 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 Cincinnati VA Medical Center, Cincinnati, Ohio,* Report No. 07-01149-182, August 2, 2007). 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 for 166 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 Strengths

Mobile Health Unit Outreach Initiative

The medical center is making creative use of its new 20-foot mobile health unit (the Unit), improving its veteran outreach efforts. Every Friday through Sunday, the Unit is scheduled for high visibility venues, focusing on events with large attendance—professional football and baseball games and major community events. In addition, the Unit travels to community veterans organization locations, National Guard and Reserve sites, and local colleges to facilitate veteran access to benefits and services.

The Unit optimizes opportunities to introduce veterans to the benefits and services available at the medical center and provides a streamlined transition to VA health care services. It is a one-stop clinic where veterans can enroll for care, complete an initial mini-vesting examination, receive mental health counseling, and schedule future appointments. The Unit is staffed full-time by a public affairs specialist, an eligibility clerk, and a driver. Other staff support includes nurse practitioners, licensed practical nurses, and mental health professionals.

Successful outcomes from use of the Unit include reduced travel for veterans to access care, engagement of returning Iraq and Afghanistan veterans outside the traditional operating hours and in a more convenient location for them, and increased awareness of VA services by families and friends of veterans. Importantly, the Unit has enrolled more than 500 new veterans for care at the medical center.

Post-Traumatic Stress Disorder and Anxiety Disorders Program Women's Residential Rehabilitation Treatment Program

The medical center's PTSD and Anxiety Disorders Program opened the Women's PTSD RRTP in January 2007. The program admits all women veterans and active duty personnel. Program treatment lasts 7 weeks and is based on Cognitive Processing Therapy (CPT), one of the two evidence-based treatments for PTSD used by VA.

Patients are admitted in a "cohort" of women who receive treatment as a group and are discharged together at the completion of treatment. This allows for a sense of connection and responsibility amongst patients and staff that might not otherwise develop in a rolling admission format.

CPT is provided in both combined group and individual formats with twice weekly individual and group therapy sessions with an all female therapy staff (unless otherwise requested). Trauma treatment is supplemented with psychoeducational group therapy, including communication, mindfulness meditation, distress tolerance, women's health issues, interpersonal effectiveness, and anger management.

The medical center has treated more than 100 female veterans. Seventy percent of the patients discharged no longer meet the criteria for a PTSD diagnosis, and the remaining 30 percent have all shown clinically significant improvement.

Results

Review Activities With Recommendations

Quality Management

The purposes of this review were to determine whether the medical center had a comprehensive, effective QM program designed to monitor patient care activities and coordinate improvement efforts and whether 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 11 areas. However, we identified the following area that needed improvement.

Peer Review Data. VHA policy[1] requires the reporting of peer review data to the facility's Executive Committee of the Medical Staff quarterly. The medical center was collecting and monitoring the required peer review data, including peer review level and level changes, but the data were not reported quarterly to the Medical Executive Committee.

Recommendation 1 We recommended that the VISN Director ensure that the Medical Center Director requires that peer review data are reported to the Medical Executive Committee, as required by VHA policy.

The VISN and Medical Center Directors concurred with the findings and recommendation. In FY 2008, there was a transition in personnel, and peer review data were not reported to the Medical Executive Committee. At the time of this inspection, the medical center had already remedied this and for the last several quarters had been reporting data to the Medical Executive Committee. The corrective actions are acceptable, and we consider this recommendation closed.

Environment of Care

The purpose of this review was to determine whether VHA facilities maintained a safe and clean health care environment. VHA facilities are required to establish a comprehensive EOC program that fully meets VHA, Joint Commission (JC), National Center for Patient Safety, Occupational Safety and Health Administration (OSHA), and National Fire Protection Association standards.

At the Ft. Thomas division, we inspected the CLC unit and the PTSD-RRTP unit. At the Cincinnati division, we inspected the surgical intensive care unit, the medical intensive care unit, the post-anesthesia care unit, the hemodialysis unit, primary care clinics, the locked inpatient behavioral health units, and all inpatient units. Overall, we found the areas we inspected to be clean and well maintained.

We found that prior to September 2009, documentation of the fire drill evaluation of the MRI suite was not available. The medical center recognized this deficiency and has taken action to correct it. Therefore, we did not make a

[1] VHA Directive 2008-004, *Peer Review for Quality Management*, January 28, 2008.

recommendation related to this finding. However, we identified the following conditions that needed improvement.

Respirator Fit Testing. OSHA policy for respirator fit testing directs that individuals identified to wear an N95 respirator must undergo initial and annual fit testing, training, and initial medical evaluation. Respirators will be provided to these employees when it is necessary to protect their health. The H1N1 flu pandemic enhances the need for the medical center to develop and implement a written respiratory protection program with required worksite-specific procedures and elements for required respirator use.

We reviewed the fit testing training records for employees from four clinical areas for compliance. Nineteen (83 percent) of the 23 employees received the training and completed annual fit testing.

Training. VHA policy[2] requires employees on locked inpatient behavioral health units and members of the Multidisciplinary Safety Inspection Team (MSIT) to complete training on environmental hazards that represent a threat to suicidal patients. Three of the 8 new employees on the locked behavioral health units and 5 (45 percent) of the 11 members of the EOC MSIT team had current training on identifying and correcting environmental hazards specific to these units. In addition, we examined the infection control training records of 24 employees from one inpatient unit and one outpatient unit and found that 20 (83 percent) employees had completed the required annual OSHA Bloodborne Pathogens Rule training.

NAPR. Daily negative airflow logs for occupied isolation rooms were not maintained in accordance with local policy. When questioned, clinical staff on floors where NAPRs were located did not know if clinical or engineering staff conducted the daily checks. Clinical staff who did conduct the daily checks did not document them.

Recommendation 2 We recommended that the VISN Director ensure that the Medical Center Director fully implements a comprehensive respiratory protection program.

[2] Deputy Under Secretary for Health for Operations and Management, "Mental Health Environment of Care Checklist," memorandum, August 27, 2007.

The VISN and Medical Center Directors concurred with the finding and recommendation. A comprehensive respiratory management protection process has been developed. Monthly reminders are now being sent to all supervisors regarding staff needing fit testing. Fit testing completion is documented in the VA Learning Management System (LMS), and quarterly reports of fit testing compliance will be presented to and discussed in the Safety 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 addresses the identified mental health and infection control training deficiencies.

The VISN and Medical Center Directors concurred with the findings and recommendation. Locked behavioral health unit staff and members of the EOC MSIT team had completed the required training, but it was not recorded in LMS. This training is now recorded in LMS. Annual infection control training is assigned in LMS. Supervisors will review their employees' training requirements during annual rating evaluations to ensure compliance. 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 NAPR logs are properly maintained and that staff are educated on their responsibilities.

The VISN and Medical Center Directors concurred with the findings and recommendation. Nursing Service will now conduct the daily checks and maintain the NAPR logs. Engineering Service will monitor compliance monthly. 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 inpatient medicine/surgery, mental health, and CLC units.

We found that the medical center had a designated Bar Code Medication Administration Program coordinator who had appropriately identified and addressed problems.

However, we identified the following area that needed improvement.

Pain Medication Effectiveness Documentation. Local policy requires that nurses assess the effectiveness of PRN (as needed) pain medications within 60 minutes after administration and document effectiveness within 4 hours of administration. We reviewed the medical records of 20 patients who received 78 doses of pain medications. Only 60 (77 percent) of the 78 doses had effectiveness documented within the timeframe specified by local policy.

Recommendation 5 We recommended that the VISN Director ensure that the Medical Center Director requires timely assessment and documentation of pain medication effectiveness and monitoring of data to ensure compliance with local policy.

The VISN and Medical Center Directors concurred with the finding and recommendation. Bar Code Medication Administration reports are being run every 3 hours on all inpatient units, and charge nurses are addressing any discrepancies. Twice a day chief nurses will run reports and review them. The Quality Performance Council will monitor compliance. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

Contracted/Agency Registered Nurses

The purpose of this review was to evaluate whether RNs working at the medical center through contracts or temporary agencies met the same entry requirements as RNs hired as part of VHA facility staff. We examined 10 files of contracted/agency RNs who worked at the medical center within the past year. We reviewed documents for several required components, including background investigations, licensure, training, competencies, and monthly evaluations. We identified two areas that needed improvement.

Monthly Evaluations. Local policy requires monthly documented evaluations for each agency RN employed. Of the 10 files we reviewed, we found that only 1 (10 percent) contained the required evaluations.

Clinical Competence. Local policy requires contracted agencies to provide documented evidence of current clinical competence before agency RNs provide patient care at the medical center. Of the 10 files we reviewed, we found that

only 1 (10 percent) contained current clinical competency documentation.

Recommendation 6 We recommended that the VISN Director ensure that the Medical Center Director requires that monthly evaluations are completed and that clinical competencies are demonstrated and documented for all contracted/agency RNs.

The VISN and Medical Center Directors concurred with the findings and recommendation. An action plan that included redefining roles and responsibilities related to monthly evaluations and current clinical competencies for contract agency staff was developed and implemented. All contract nursing personnel folders are now kept and managed by the staffing specialist in Nursing Service who will ensure that annual competencies are received and that monthly evaluations are completed. The Council of Chief Nurses will monitor the processes quarterly. 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 intra-facility transfers, discharges, and post-discharge mental health care were coordinated appropriately over the continuum of care and met VHA and JC requirements. Coordinated transfers, discharges, and post-discharge mental health care are essential to an integrated, ongoing care process and optimal patient outcomes.

We reviewed the documentation for 20 intra-facility transfers and determined that clinicians appropriately managed all 20. 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 40 patients who were discharged and found that patients received appropriate written discharge instructions. We also found documentation that the patients understood those instructions.

Additionally, we reviewed the medical records of 10 patients recently discharged from the acute mental health unit. We found documentation that patients received information

about accessing emergency mental health care and that patients were given mental health clinic appointments within 2 weeks of discharge. We also found documentation that mental health providers either arranged for follow-up appointments or contacted the patients by phone within 7 days of discharge. We made no recommendations.

Magnetic Resonance Imaging Safety

The purpose of this review was to evaluate whether the medical center maintained a safe environment and safe practices 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 medical center had adequate safety policies and had appropriately conducted a risk assessment of the environment, as required by the JC.

The medical center had appropriate signage and barriers to prevent unauthorized or accidental access to the MRI area. Patients in the magnet room are directly observed at all times. Two-way communication is available between the patient and the MRI technologist, and the patient has access to a push-button call system while in the scanner. Additionally, mock fire and emergency response drills have recently been conducted in the MRI area.

Local policy requires that personnel who have access to the MRI area receive appropriate MRI safety training. We reviewed the training records of 12 personnel and found that all had completed required safety training. In addition, we reviewed the medical records of 10 patients who received an MRI. In all cases, patients received appropriate screening. We made no recommendations.

Physician Credentialing and Privileging

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

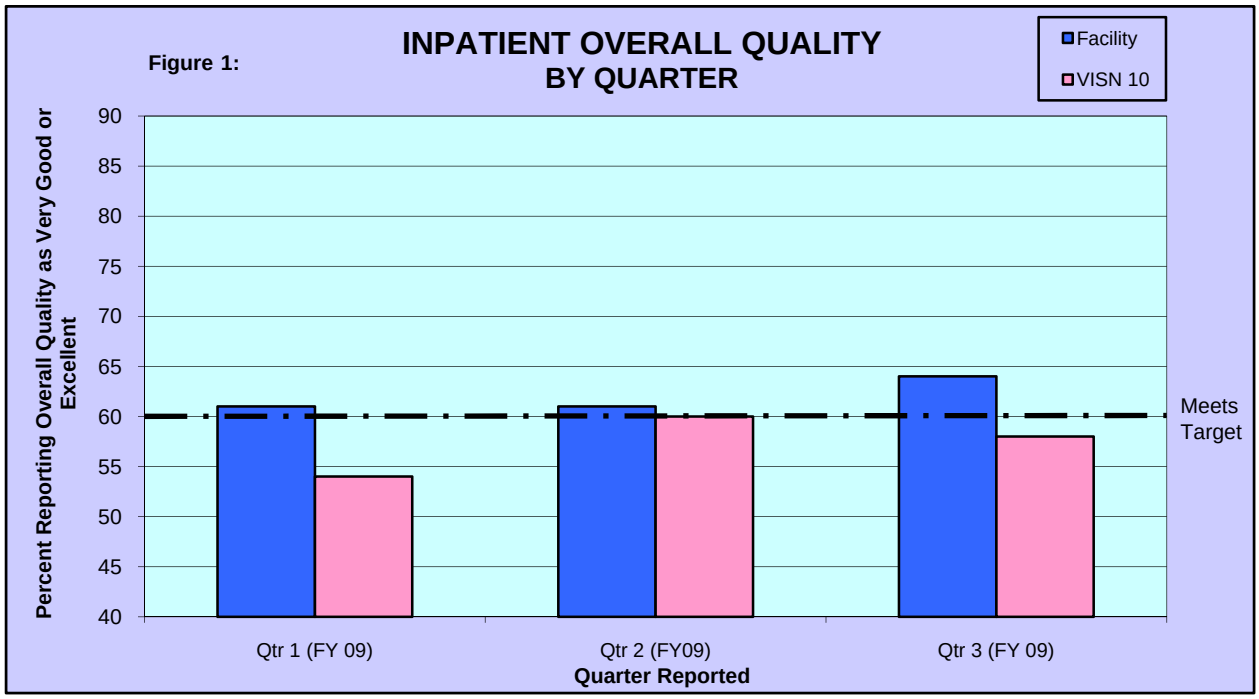
We reviewed 10 credentialing and privileging files and profiles and found that licenses were current and that primary source verification had been obtained. Focused

Professional Practice Evaluation was appropriately implemented for newly hired physicians. Service-specific criteria for Ongoing Professional Practice Evaluation had been developed and approved. In addition, we found sufficient performance data to meet current requirements. We made no recommendations.

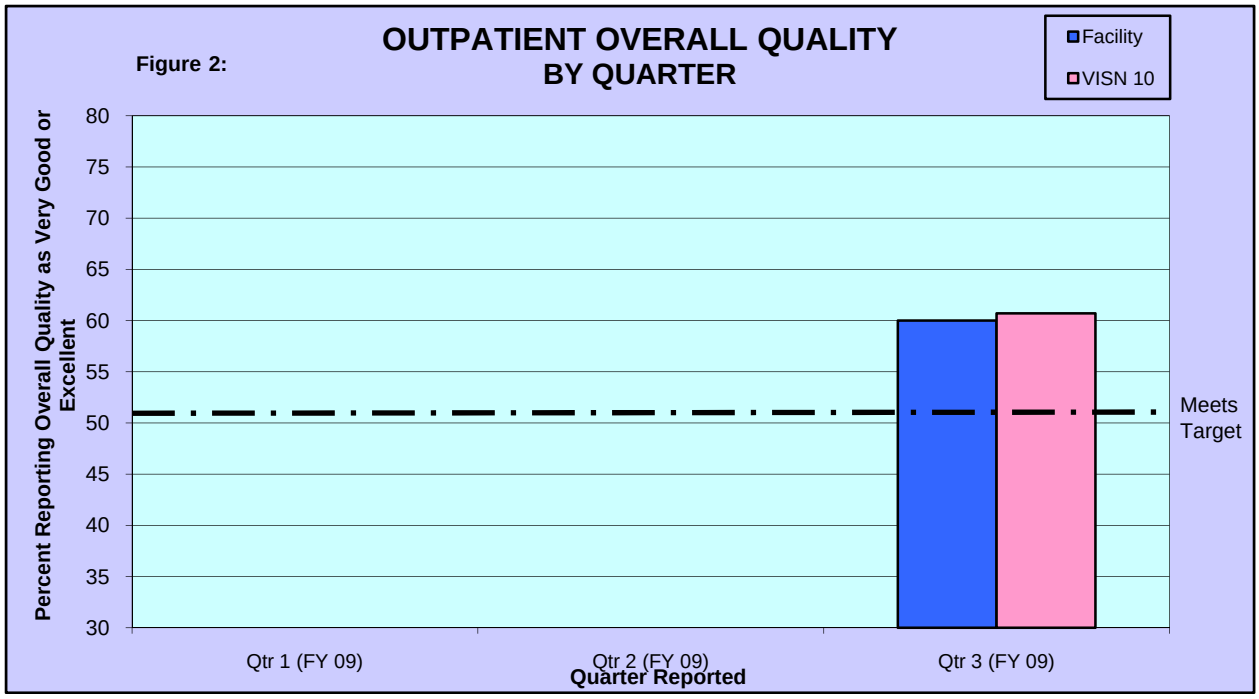
VHA Satisfaction Surveys

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 1–3 of FY 2009. Figure 2 on the next page shows the medical center's and VISN's overall outpatient satisfaction scores for quarter 3 of FY 2009.[3] The target scores are noted on the graphs.

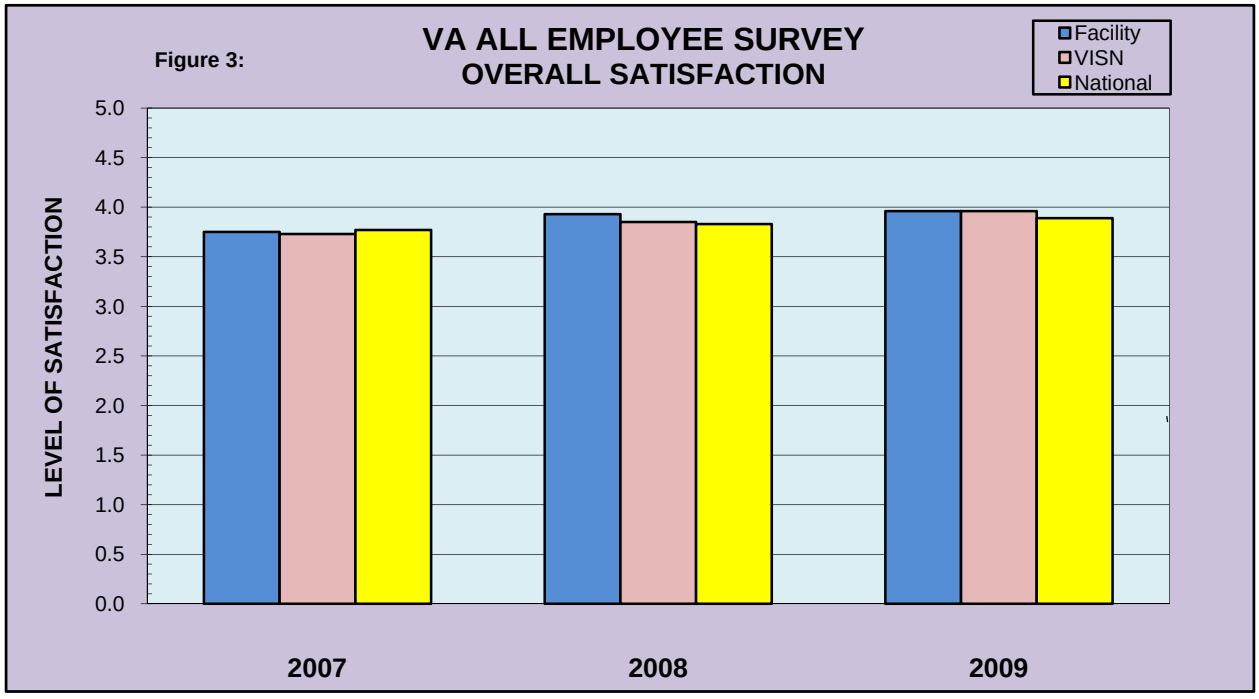
Figure 1:



[3] Due to technical difficulties with VHA's outpatient survey data, outpatient satisfaction scores for quarters 1 and 2 of FY 2009 are not included for comparison.



Employees are surveyed annually. Figure 3 below 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.



VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: January 25, 2010

From: Director, VA Healthcare System of Ohio (10N10)

Subject: **Combined Assessment Program Review of the Cincinnati VA Medical Center, Cincinnati, Ohio**

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

Director, Management Review Service (10B5)

1. I have reviewed the comments provided by the Medical Center Director, Cincinnati VA Medical Center and concur with the responses and proposed action plans to the recommendations outlined in the report.

2. We appreciate the opportunity for this review as a continuing process to improve the care to our veterans. The Office of Inspector General Continuous Assessment Program Team was professional and consultative during the review.

3. If further information is required, please contact Jane Johnson, RN, MS, Accreditation Specialist, Cincinnati VA Medical Center, at (513) 861-3100, extension 5239.

/S/

JACK G. HETRICK, FACHE

Appendix B

Medical Center Director Comments

Department of Veterans Affairs **Memorandum**

Date: January 25, 2010

From: Director, Cincinnati VA Medical Center (539/00)

Subject: **Combined Assessment Program Review of the Cincinnati VA Medical Center, Cincinnati, Ohio**

To: Director, VA Healthcare System of Ohio (10N10)

1. Attached please find the VHACIN responses and relevant action plan for the 6 recommendations from the Office of the Inspector General Combined Assessment Program Review conducted November 30-December 3, 2009.

2. We appreciate the professionalism demonstrated by the OIG CAP Team and the consultative attitude demonstrated during the review process.

3. If you have any questions regarding this report, please contact Jane Johnson, RN, MS, Cincinnati VA Medical Center Accreditation Specialist, at 513 861-3100, extension 5239.

/S/

LINDA D. SMITH, 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:

OIG Recommendations

Recommendation 1. We recommended that the VISN Director ensure that the Medical Center Director requires that peer review data are reported to the Medical Executive Committee, as required by VHA policy.

Concur

In FY 08, the Cincinnati VAMC experienced a transition in personnel in Quality Management, including the loss of the Peer Review Specialist. During this transition, Peer Review data was not reported to the Clinical Executive Board. At the time of the inspection the facility had already remedied this finding and had been reporting robust data reports per VHA Directive 2008-004, *Peer Review for Quality Management*, to the Clinical Executive Board. For the last several quarters, Peer Review Data was presented and discussed in Clinical Executive Board. At the time of the OIG Inspection this reporting was noted.

Completion Date: 12/3/09

Recommendation 2. We recommended that the VISN Director ensure that the Medical Center Director fully implements a comprehensive respiratory protection program.

Concur

A Respirator Fit Testing program was in place at the time of this inspection. However, a more comprehensive respiratory management protection process has been developed to ensure improved oversight of this process. Industrial Hygiene and Safety, along with Employee Health and Infection Prevention and Control, utilize the Center for Disease Control's Guidelines generated by the Pandemic Influenza Bulletin to categorize risk level for each employee. The Medical Center uses the assessment process developed by the DUSHOM to determine who should be fit tested. Based on these guidelines, employees needing respirator fit testing are designated and Employee Health physical/clearance and fit testing are completed and documented. Monthly reminders are now being sent to all supervisors regarding staff needing fit testing. Fit testing completion is documented in VA Learning Management System (LMS) and monitored by the supervisor at the time of the employee's proficiency.

Quarterly reports of fit testing compliance are presented and discussed in the Safety Committee. An annual review of the program and data are reported through the Safety Committee.

Completion Date: 1/5/2010, ongoing monitoring and reporting to Safety Committee.

Recommendation 3. We recommended that the VISN Director ensure that the Medical Center Director addresses the identified mental health and infection control training deficiencies.

Concur

At the time of the inspection, all Mental Health EOC Multidisciplinary Safety Inspection Team (MSIT) staff had completed specialized training related to identifying hazards within the environment of care. This training had not been recorded within LMS. Training for Mental Health staff on the inpatient unit related to the safety and risk issues in the environment had been completed, but not recorded within LMS. This training is now recorded in LMS.

Annual Infection Control trainings, specifically OSHA Bloodborne Pathogens Training, are assigned in LMS. Each supervisor reviews their employees training requirements at the time of each employee's annual rating evaluation to ensure compliance.

Completion Date: 1/14/2010

Recommendation 4. We recommended that the VISN Director ensure that the Medical Center Director requires that NAPR logs are properly maintained and that staff are educated on their responsibilities.

Concur

Nursing has revised its processes to include the monitoring and logging of Negative Air Pressure Rooms (NAPR) during their daily logging of the Crash Cart. Negative Air Pressure Rooms are monitored and logged daily by nursing staff and will continue to be monitored and logged monthly by Engineering.

Completion Date: 12/17/09

Recommendation 5. We recommended that the VISN Director ensure that the Medical Center Director requires timely assessment and documentation of pain medication effectiveness and monitoring of data to ensure compliance with local policy.

Concur

Bar Code Medication Administration (BCMA) reports are run every three hours on all inpatient units by the Nurse Manager/Charge Nurse to ensure follow-up documentation consistent with Medical Center policy. Charge nurses address any discrepancies within this three hour window. Twice daily these reports are run and reviewed with the Chief Nurses. A sample is run monthly of PRN medication effectiveness and tracked, trended and reported through the Quality Performance Council (QPC). The most recent data demonstrates PRN (as needed) pain effectiveness documentation has improved throughout the organization. In order to sustain this improvement this monitor will be ongoing for the organization.

Completion Date for Process Changes: 12/15/09, Monitoring of this process is ongoing and reported monthly through Quality Performance Council.

Recommendation 6. We recommended that the VISN Director ensure that the Medical Center Director requires that monthly evaluations are completed and that clinical competencies are demonstrated and documented for all contracted/agency RNs.

Concur

An action Plan was developed and implemented on 12/10/09 to include redefining the role and responsibility of the Contracting Officer's Technical Representative (COTR), the Staffing Specialist, Nursing Education, Nursing Managers/Nursing Officer of the Day (NOD) and the Chief Nurse related to monthly evaluations and current clinical competencies for contract agency staff. Nursing Policy related to the use of contract nursing staff has been revised and includes these roles and responsibilities. All contract nursing personnel folders are now kept and managed by the Staffing Specialist in Nursing Service who ensures annual competencies are received and monthly evaluations are completed. The Nurse Manager/NOD is responsible for completing monthly evaluations. The Council of Chief Nurses will monitor these processes quarterly.

Completion Date: 1/14/10

OIG Contact and Staff Acknowledgments

Contact	Randall Snow, Director Washington, DC, Office of Healthcare Inspections (410) 637-4723
Contributors	Jennifer Christensen, Team Leader Bruce Barnes Gail Bozzelli Rutledge Davis III Donna Giroux Kimberly Pugh Richard A. Horansky, Office of Investigations Gavin T. McClaren, Office of Investigations John D. Metzler, Office of Investigations

Report Distribution

VA Distribution

Office of the Secretary
Veterans Health Administration
Assistant Secretaries
General Counsel
Director, VA Healthcare System of Ohio (10N10)
Director, Cincinnati VA Medical Center (539/00)

Non-VA Distribution

House Committee on Veterans' Affairs
House Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
House Committee on Oversight and Government Reform
Senate Committee on Veterans' Affairs
Senate Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
Senate Committee on Homeland Security and Governmental Affairs
National Veterans Service Organizations
Government Accountability Office
Office of Management and Budget
U.S. Senate: Sherrod Brown, George V. Voinovich
U.S. House of Representatives: Steve Driehaus

This report is available at http://www.va.gov/oig/publications/reports-list.asp.