Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 10-00050-247

Combined Assessment Program Review of the Tuscaloosa VA Medical Center Tuscaloosa, Alabama

September 15, 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 crime awareness briefings to increase employee understanding of the potential for program fraud and the requirement to refer suspected criminal activity to the OIG.

In addition to this typical coverage, CAP reviews may examine issues or allegations referred by VA employees, patients, Members of Congress, or others.

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Glossary

AAMI	Association for the Advancement of Medical Instrumentation
BCMA	Bar Code Medication Administration
C&P	credentialing and privileging
CAP	Combined Assessment Program
CLC	community living center
COC	coordination of care
COS	Chief of Staff
CPRS	Computerized Patient Record System
EOC	environment of care
ESA	erythropoiesis-stimulating agent
facility	Tuscaloosa VA Medical Center
FPPE	Focused Professional Practice Evaluation
FTE	full-time employee equivalents
FY	fiscal year
JC	Joint Commission
MH	mental health
MSEC	Medical Staff Executive Committee
NCPS	National Center for Patient Safety
NFPA	National Fire Protection Association
OIG	Office of Inspector General
OPPE	Ongoing Professional Practice Evaluation
OSHA	Occupational Safety and Health Administration
PI	performance improvement
PRC	Peer Review Committee
PRRTP	Psychosocial Residential Rehabilitation Treatment Program
QM	quality management
RME	reusable medical equipment
SOP	standard operating procedure
SPD	Supply, Processing, and Distribution
SPP	Suicide Prevention Program
UM	utilization management
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Table of Contents

Executive Summary: Combined Assessment Program Review of the Tuscaloosa VA Medical Center, Tuscaloosa, Alabama

Review Purpose: The purpose was to evaluate selected activities, focusing on patient care administration and quality management, and to provide crime awareness training. We conducted the review the week of May 24, 2010.

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

- Medication Management
- Physician Credentialing and Privileging
- Suicide Prevention Safety Plans

The facility's reported accomplishments included their *U.S. News & World Report* ranking in the top 60 psychiatric facilities in the country and veteran- and family-centered care/cultural transformation. Additional accomplishments were the Veteran of the Month Program and the Operation Enduring Friendship outreach service, which pairs employees with deployed soldiers and/or their families to provide assistance and emotional support.

Recommendations: We made recommendations in the following four activities:

Quality Management: Peer Review Committee minutes need to include documentation of discussions with providers and feedback from actions and recommendations. Adverse event documentation needs to be improved. Patient complaints need to be thoroughly analyzed, and actions and follow-up need to be tracked to completion. Physician utilization management advisors need to complete required training.

Coordination of Care: Inter-facility transfer documentation, physician discharge orders, and patient discharge instructions need to include all required elements.

Environment of Care: Designated employees need to receive the required annual N95 fit testing.

Reusable Medical Equipment: Monitoring results need to be reported quarterly to the Medical Staff Executive Committee.

Comments

The Veterans Integrated Service Network and Facility Directors agreed with the Combined Assessment Program review findings and provided acceptable improvement plans. 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

Objectives and Scope

Objectives

Objectives. CAP reviews are one element of the OIG's efforts to ensure that our Nation's veterans receive high quality VA health care services. The objectives of the CAP review are to:

- Conduct recurring evaluations of selected health care facility operations, focusing on patient care administration and QM.
- Provide crime awareness briefings to increase employee understanding of the potential for program fraud and the requirement to refer suspected criminal activity to the OIG.

Scope

Scope. We reviewed selected clinical and administrative activities to evaluate the effectiveness of patient care administration and QM. Patient care administration is the process of planning and delivering patient care. QM is the process of monitoring the quality of care to identify and correct harmful and potentially harmful practices and conditions.

In performing the review, we inspected selected areas, interviewed managers and employees, and reviewed clinical and administrative records. The review covered the following seven activities:

- COC
- EOC
- Medication Management
- Physician C&P
- QM
- RME
- Suicide Prevention Safety Plans

The review covered facility operations for FY 2008, FY 2009, and FY 2010 through May 24, 2010, and was done in accordance with OIG SOPs for CAP reviews. We also followed up on selected recommendations from our prior CAP review of the facility (*Combined Assessment Program*

Review of the Tuscaloosa VA Medical Center, Tuscaloosa, Alabama, Report No. 07-00157-97, March 14, 2007). The facility had corrected all EOC findings; however, we identified one repeat finding in QM.

During this review, we also presented crime awareness briefings to 359 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.

Reported Accomplishments

Hospital Ranking

In 2009, *U.S. News & World Report* ranked the facility in the top 60 psychiatric facilities in the country. The MH recovery program led to the facility's 52nd place ranking.

Veteran- and Family-Centered Care/Cultural Transformation

The facility has made cultural transformation and veteran- and family-centered care a priority focus area. The concept of veteran- and family-centered care/cultural transformation is included in the facility's goal-sharing program and in each employee's performance standards. Cultural transformation in the MH, CLC, and primary care areas included both physical and programmatic changes. Removing nurses' stations, adding home-like furnishings, and creating a gated outdoor courtyard are some of the physical changes implemented. Programmatic changes included expanded visiting hours, dance parties, and a resident pet. The cultural transformation has created a positive environment that facilitates veteran and family involvement in the development and implementation of treatment plans and encourages their participation in recreational and therapeutic activities.

Veteran of the Month Program

The Veteran of the Month Program recognizes the achievements and special contributions of the facility's veteran patients and veteran staff members. Veterans are nominated by their peers or staff members for their outstanding contributions to other veterans and the facility. After selection, these deserving veterans have their photos displayed on the "Wall of P.R.I.D.E."

Operation Enduring Friendship

This outreach service pairs a team of employees with deployed soldiers and/or their families to provide assistance with small home projects and emotional support. One team supported a staff nurse with four small children whose husband was deployed. In addition, Human Resources provides an Employee Assistance Program for families of veterans who are having issues related to post-deployment readjustment.

Results

Review Activities With Recommendations

QM

The purpose of this review was to evaluate whether the facility had a comprehensive QM program designed to monitor patient care quality and whether senior managers actively supported the program's activities. We interviewed the facility's Director, the COS, and selected QM staff. We evaluated plans, policies, PI data, and other relevant documents.

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

PRC. VHA policy[1] requires that PRC minutes include documentation of discussions with providers who are assigned level 2 or 3 final peer review determinations and actions taken related to those findings. We found that the PRC performed most peer review processes well. However, service chief communication with the provider and feedback to the PRC related to non-punitive actions or recommendations were not documented as required.

Adverse Event Disclosure. VHA policy[2] requires a process to be in place to evaluate adverse events for possible disclosure, and there are specific documentation requirements based upon the significance of the event. Routine clinical disclosures are not to be documented on the CPRS disclosure template note but should instead be documented within clinicians' progress notes. The facility had a process in place to evaluate and disclose adverse events. However, we found multiple routine clinical

[1] VHA Directive 2008-004, *Peer Review for Quality Management*, January 28, 2008.
[2] VHA Directive 2008-002, *Disclosure of Adverse Events to Patients*, January 18, 2008.

disclosures incorrectly documented on the CPRS template note. We found that the template included information concerning the right to file administrative or tort claims, which is appropriate only for the more serious institutional disclosures.

Patient Complaints. VHA policy[3] requires that patient complaints be critically analyzed to determine patterns and trends to target improvement initiatives. We found that complaints were not thoroughly analyzed to identify patterns and trends and that tracking of service line actions and follow-up was not completed.

UM. VHA policy[4] requires that physician UM advisors obtain training specific to the functions of the appointed position. We found that two physicians appointed as UM advisors did not have the required training. This is a repeat finding from the previous CAP review.

Recommendations

1. We recommended that PRC minutes include documentation of discussions with providers and feedback from actions and recommendations, as required by VHA policy.

2. We recommended that adverse events be documented in accordance with VHA policy.

3. We recommended that patient complaints be analyzed in detail and that service line actions and follow-up be tracked to completion.

4. We recommended that physician UM advisors receive the required training.

COC

The purpose of this review was to evaluate whether inter-facility transfers and discharges were coordinated appropriately over the continuum of care and met VHA and JC requirements. Coordinated transfers and discharges are essential to an integrated, ongoing care process and optimal patient outcomes.

VHA requires[5] that facilities have a policy that ensures the safe, appropriate, and timely transfer of patients and that transfers are monitored and evaluated as a part of the QM

[3] VHA Handbook 1003.4, *VHA Patient Advocacy Program,* September 2, 2005.
[4] VHA Directive 2005-040, *Utilization Management Policy*, September 22, 2005.
[5] VHA Directive 2007-015, *Inter-Facility Transfer Policy*, May 7, 2007.

program. We determined that the facility had an appropriate transfer policy and monitored and evaluated transfers as a part of the QM program. However, we identified the following areas that needed improvement.

Inter-Facility Transfers. VHA policy requires specific information (such as the reason for transfer, mode of transportation, and informed consent to transfer) to be recorded in the transfer documentation. We reviewed transfer documentation for 10 patients transferred from the facility's acute psychiatric inpatient unit to another facility. We found that none of the records contained all required elements. Missing information included the level of care or services required at the receiving facility (8 (80 percent) of the 10 records), medical care required during transport (9 (90 percent) of the 10 records), and informed consent to transfer (8 (80 percent) of the 10 records).

Discharges. VHA policy[6] requires that providers include information regarding medications, diet, activity level, and follow-up appointments in patient discharge instructions. The JC requires that clinicians provide patients with written discharge instructions. In addition, local policy requires that physician discharge orders include medications, equipment, and follow-up plans. We reviewed the medical records of 10 discharged patients and found that none of the records contained all of the required elements for physician discharge orders. In addition, 2 (20 percent) of the 10 patients did not have follow-up appointments included in the discharge instructions, and 2 (20 percent) of the 10 patients were discharged with special dietary requirements, yet there was no documentation of dietary instructions in the patient discharge instructions.

Recommendations

5. We recommended that inter-facility transfer documentation contain all required elements.

6. We recommended that physician discharge orders and patient discharge instructions include all required elements.

EOC

The purpose of this review was to determine whether the facility maintained a safe and clean health care environment. VHA facilities are required to establish a comprehensive

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

EOC program that fully meets VHA, NCPS, OSHA, NFPA, and JC standards.

We inspected the acute locked inpatient MH unit, two locked inpatient MH recovery units, the acute rehabilitation unit, one CLC unit, the hospice and palliative care unit, the inpatient/outpatient laboratory, the dental clinic, the MH outpatient clinic, and four primary care/specialty clinics.

The infection control program appropriately aggregated and analyzed hand hygiene data for PI. In addition, the data was consistently reported to the Infection Control Committee when trends or educational needs that required follow-up were identified. Also, the facility had conducted fire drills once per shift per quarter in each building designated for health care occupancy, as required by NFPA regulations and JC standards.

The facility maintained a generally clean and safe environment. Employees from Nursing and Environmental Management Services had completed the annual bloodborne pathogens training for FY 2009, as required by OSHA. In addition, all members of the MH Multidisciplinary Safety Inspection Team had completed the annual training for FY 2009 on environmental hazards that represent a threat to suicidal patients.

VHA requires[7] mechanical hospital beds specified for patients with medical needs on locked inpatient MH units to be placed in rooms close to the nursing station. These beds have additional parts that could be used as anchor points, posing potential safety risks. On the acute locked inpatient MH unit, we found an unoccupied, manually adjustable mechanical hospital bed in a double occupancy room. The other bed was occupied by a patient, and the room was located away from the nursing station. In addition, we found two other unoccupied mechanical beds in a double occupancy room on the unit also located away from the nursing station. This room was unsecured, and patients had access to the beds through the open door. While we were onsite, managers provided us with a work order reflecting the removal of the unoccupied mechanical bed located in the first room and the removal of one of the beds from the second room. The third mechanical bed later became occupied by a patient who was placed in a room located

[7] VHA National Center for Patient Safety, "Mental Health Environment of Care Checklist," April 8, 2010.

close to the nursing station. Therefore, we made no recommendation for these findings. However, we identified the following condition that needed improvement.

N95 Respirator Fit Testing. Centers for Disease Control and Prevention guidelines recommend that all health care personnel entering rooms of patients with confirmed, suspected, or probable H1N1 influenza should wear, at a minimum, a fit tested N95[8] respirator. In addition, OSHA standards require designated staff to be medically cleared, fit tested, and trained for respirator use as part of a complete respiratory protection program. We found that only 11 (39 percent) of 28 selected employees from radiology, the primary care/specialty clinics, the inpatient/outpatient laboratory, and the MH outpatient clinic had received the required annual N95 fit testing.

Recommendation

7. We recommended that designated employees receive annual N95 fit testing, as required.

RME

The purpose of this review was to evaluate whether the facility had processes in place to ensure effective reprocessing of RME. Improper reprocessing of RME may transmit pathogens to patients and affect the functionality of the equipment. VHA facilities are responsible for minimizing patient risk and maintaining an environment that is safe. The facility's SPD area is required to meet VHA, AAMI, OSHA, and JC standards.

We inspected the SPD area. For five pieces of RME, we reviewed the SOPs for reprocessing. We determined that the facility had established appropriate SOPs for reprocessing equipment and had appropriate infection prevention controls in place. Also, the facility had a system in place to track RME should a sterilization failure occur. We reviewed the competency folders and training records of the employees who demonstrated or verbalized cleaning procedures and found that annual competencies and training were current and consistently documented.

OSHA requires that an eyewash station be available for immediate use in areas where employees could be exposed to injurious, corrosive chemicals. We noted that the decontamination room did not have an eyewash station

[8] A disposable particulate respirator that has the ability to filter out 95 percent of particles greater than 0.3 microns in diameter.

within the immediate vicinity. A permanent eyewash station was installed while we were onsite. Therefore, we made no recommendation for this finding.

For maximum effectiveness and safety, VA requires[9] that manufacturers' instructions be followed for cleaning solutions used in reprocessing RME. We found a sink in the SPD decontamination area that was not marked to show the correct proportions of water and cleaning solution to be used. The deficiency was corrected while we were onsite; therefore, we made no recommendation for this finding. However, we identified the following area that needed improvement.

Reporting of Monitoring Results. VHA[10] and local policy require that an interdisciplinary team monitor initial and ongoing competency validation, compliance with SOPs, results of infection prevention monitoring, and risk management activities associated with RME. Results should be reported to the MSEC quarterly. We found that appropriate monitoring was being done, but results were not reported, as required.

Recommendation

8. We recommended that monitoring results be reported quarterly to the MSEC, as required.

Review Activities Without Recommendations

Medication Management

The purpose of this review was to determine whether the facility had developed effective and safe medication management practices. We reviewed selected medication management processes for outpatients and CLC residents.

The facility had implemented a practice guideline governing the maintenance of chronic renal disease patients who receive ESA therapy. The facility had a systematic process to identify and appropriately monitor patients receiving ESAs. We reviewed 10 patients' medical records and determined that clinical staff had effectively identified and addressed elevated hemoglobin levels in all 10 cases.

Influenza vaccinations were documented adequately for all 10 CLC residents whose medical records we reviewed, and clinical staff followed the established protocol when a delay

[9] VA Handbook 7176; *Supply, Processing and Distribution (SPD) Operational Requirements*; August 16, 2002.
[10] VHA Directive 2009-004, *Use and Reprocessing of Reusable Medical Equipment (RME) in Veterans Health Administration Facilities*, February 9, 2009.

in receipt of vaccines was experienced. Although the facility had an immunization template in place, it did not include a place to document the route of administration; however, the BCMA system included the required element. The facility plans to update the immunization template to include the route of administration. Therefore, we made no recommendations.

Physician C&P

The purpose of this review was to determine whether the facility had consistent processes for physician C&P. For a sample of physicians, we reviewed selected VHA required elements in C&P files and physician profiles.[11] We also reviewed meeting minutes during which discussions about the physicians took place.

We reviewed 10 C&P files and profiles and found that licenses were current and that primary source verification had been obtained. FPPE was appropriately implemented for newly hired physicians. Service-specific criteria for OPPE had been developed and approved. We found sufficient performance data to meet current requirements. Meeting minutes consistently documented thorough discussions of the physicians' privileges and performance data prior to recommending renewal of or initial requested privileges. We made no recommendations.

Suicide Prevention Safety Plans

The purpose of this review was to determine whether clinicians had developed safety plans that provided strategies to mitigate or avert suicidal crises for patients assessed to be at high risk for suicide. Safety plans should have patient and/or family input, be behaviorally oriented, and identify warning signs preceding crisis and internal coping strategies. They should also identify when patients should seek non-professional support, such as from family and friends, and when patients need to seek professional help. Safety plans must also include information about how patients can access professional help 24 hours a day, 7 days a week.[12]

A previous OIG review of suicide prevention programs in VHA facilities[13] found a 74 percent compliance rate with safety plan development. The safety plan issues identified in

[11] VHA Handbook 1100.19, *Credentialing and Privileging*, November 14, 2008.
[12] Deputy Under Secretary for Health for Operations and Management, "Patients at High-Risk for Suicide," memorandum, April 24, 2008.
[13] *Healthcare Inspection – Evaluation of Suicide Prevention Program Implementation in Veterans Health Administration Facilities January–June, 2009;* Report No. 09-00326-223; September 22, 2009.

that review were that plans were not comprehensive (did not contain the above elements), were not developed timely, or were not developed at all. At the request of VHA, the OIG agreed to follow up on the prior findings.

We reviewed the medical records of 10 patients assessed to be at high risk for suicide between November 2009 and April 2010 and found that clinicians had developed timely safety plans for all 10 patients. Plans included all required elements. We also found evidence to support that the patients participated in the development of the plans and received copies of the plans, as required.

Documentation showed that SPP staff provided excellent case management for high-risk patients, and communication between SPP staff and providers was evident. Documentation was a particular strength, further enhancing transparency and coordination of care. SPP staff placed a "flag consult" in the medical record prior to the progress note stating that the patient's record was flagged. Also, there was a template documenting when the patient's flag status was due to be re-evaluated and another template documenting the decision to continue or discontinue the flag status. We made no recommendations.

Comments

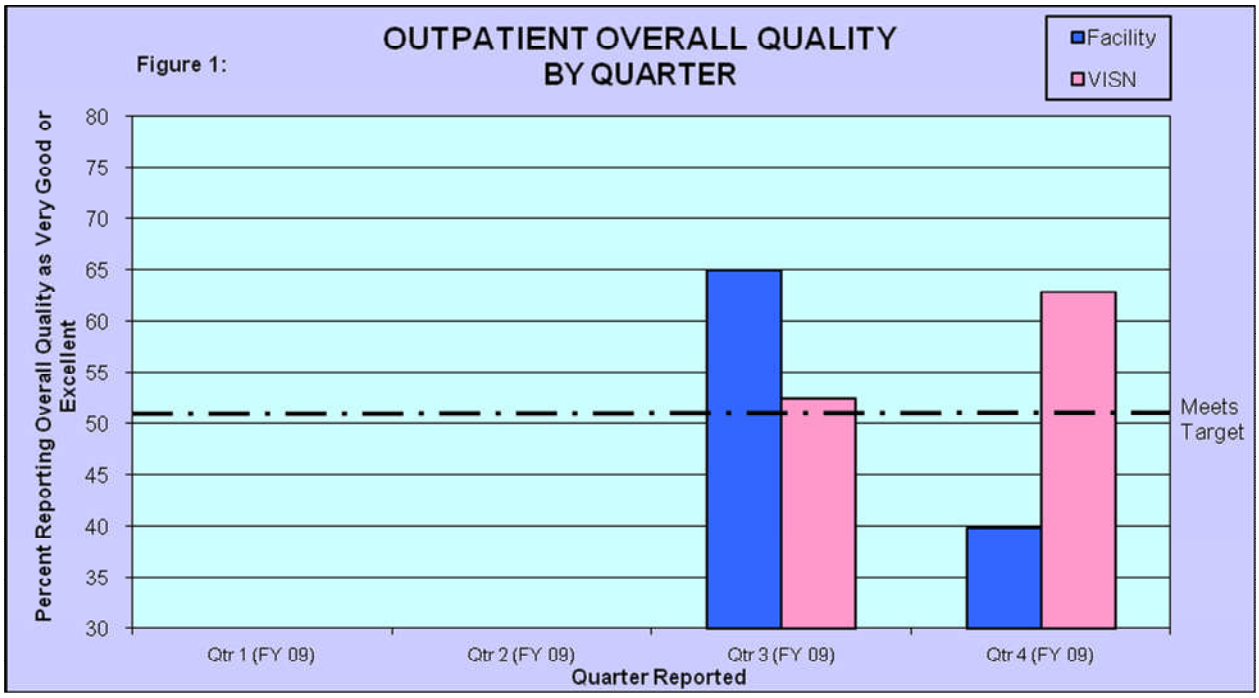
The VISN and Facility Directors agreed with the CAP review findings and recommendations and provided acceptable improvement plans. (See Appendixes C and D, pages 14–18, for the full text of the Directors' comments.) We will follow up on the planned actions until they are completed.

Facility Profile[14]		
Type of Organization	Secondary and tertiary care medical center	
Complexity Level	3	
VISN	7	
Outreach Clinic	Selma, AL	
Veteran Population in Catchment Area	32,947	
Type and Number of Operating Beds: • **Hospital, including PRRTP**	 183	
• **CLC/Nursing Home Care Unit**	198	
Medical School Affiliation(s)	University of Alabama, College of Community Medicine University of Alabama at Birmingham, AL	
• **Number of Residents**	2	
	Current FY (through March 2010)	**Prior FY**
Resources:		
• **Total Medical Care Budget**	$135,834,773.00	$130,951,686.00
• **Medical Care Expenditures**	$66,958,575.00	$130,951,686.00
Total Medical Care FTE	1,029	950
Workload:		
• **Number of Unique Patients**	14,112	15,343
• **Inpatient Days of Care:**		
o **Acute Care Psychiatry**	30,087	59,141
o **CLC**	25,007	50,141
Hospital Discharges (Hospital/Domiciliary)	482	947
Hospital Discharges (CLC)	68	134
Total Average Daily Census (including CLC patients)	295	299
Cumulative Occupancy Rate	87.6 (88 percent)	69.97 (70 percent)
Outpatient Visits	90,524	172,928

[14] All data provided by facility management.

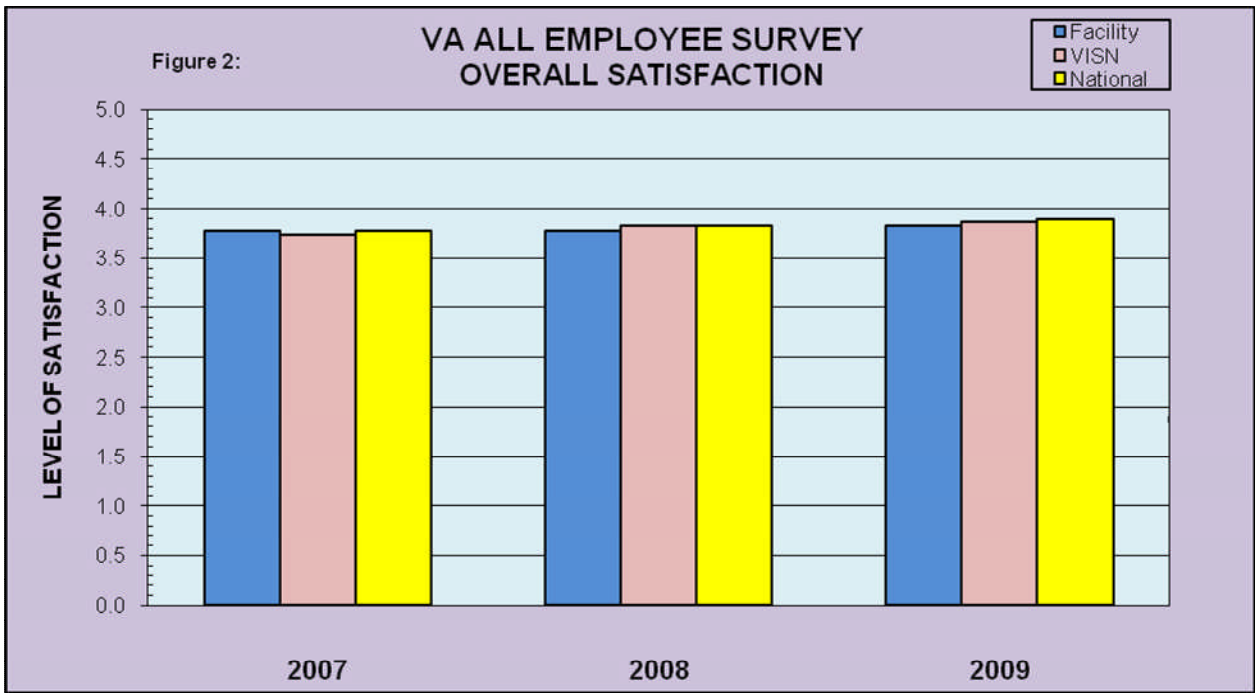
VHA Satisfaction Surveys

VHA has identified patient and employee satisfaction scores as significant indicators of facility performance. Patients are surveyed monthly, and data are summarized quarterly. No facility inpatient data was available for comparison due to the low numbers of surveys returned. Figure 1 below shows the facility's and VISN's overall outpatient satisfaction scores for quarters 3 and 4 for FY 2009.[15] The target score is noted on the graph.



[15] 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 2 below shows the facility'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: August 16, 2010

From: Director, VA Southeast Network (10N7**)**

Subject: **CAP Review of the Tuscaloosa VA Medical Center, Tuscaloosa, AL**

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

Director, Management Review Service (VHA CO 10B5 Staff)

I concur with the recommendations and approve of the action plans as outlined by the Tuscaloosa VA Medical Center.

(original signed by:)
Lawrence A. Biro
Director, VA Southeast Network, VISN 7

Facility Director Comments

Department of Veterans Affairs **Memorandum**

Date: August 16, 2010

From: Director, Tuscaloosa VA Medical Center (679/00)

Subject: **CAP Review of the Tuscaloosa VA Medical Center, Tuscaloosa, AL**

To: Director, VA Southeast Network (10N7)

1. I concur with the recommendations presented in the Combined Assessment Program Review of the Tuscaloosa VA Medical Center.

2. Attached are the facility actions taken as a result of these findings.

3. Thank you for these opportunities for improvement. The OIG Team conducted the audit in a very professional and helpful manner which made the site visit productive and educational for our staff.

4. If you have additional questions or need further information, please contact me at (205) 554-2000, ext. 2201.

(original signed by:)
Alan J. Tyler MS, MPA, FACHE
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 PRC minutes include documentation of discussions with providers and feedback from actions and recommendations, as required by VHA policy.

Concur

Target date for completion: June 30, 2010

The Peer Review Committee minutes have been revised to include documentation of discussions with providers who are assigned level 2 or 3 final peer review determinations and feedback from actions and recommendations as required by VHA policy.

Recommendation 2. We recommended that adverse events be documented in accordance with VHA policy.

Concur

Target date for completion: June 1, 2010

The Medical Center Providers have been educated regarding the process for documenting adverse events. Routine clinical disclosures are now documented in the Provider's progress notes in CPRS. Only Institutional Disclosures will be documented on the Adverse Event Disclosure Template by the Chief of Staff. The Adverse Event Disclosure Template has been updated to alert providers regarding the documentation process.

Recommendation 3. We recommended that patient complaints be analyzed in detail and that service line actions and follow-up be tracked to completion.

Concur

Target date for completion: June 30, 2010

Patient complaint data is collected by the Customer Service Department. The data is trended and critically analyzed by the Patient & Family Centered Care Committee. Service Line actions and follow-up are tracked by the Patient & Family Centered Care Committee until completion. Patient complaints are also reported to the Quality Leadership Council, when indicated.

Recommendation 4. We recommended that physician UM advisors receive the required training.

Concur

Target date for completion: August 9, 2010

The training for Physician UM Advisors was placed in LMS by VHA. The training will be completed by the UM Physician Advisor as required.

Recommendation 5. We recommended that inter-facility transfer documentation contain all required elements.

Concur

Target date for completion: June 1, 2010

The Inter-Facility Transfer Template has been revised with mandatory fields for all required documentation elements. Compliance will be tracked by the Performance Improvement Coordinators during the quarterly Medical Record Reviews, with results reported to the Chief of Staff.

Recommendation 6. We recommended that physician discharge orders and patient discharge instructions include all required elements.

Concur

Target date for completion: October 31, 2010

A discharge order set has been created for the providers, and includes all of the required documentation elements. The required documentation elements will also be included on the discharge instruction form, and presented to the patient at time of discharge. Providers will be educated at the August 2010 Medical Staff Committee. Compliance will be tracked by the Performance Improvement Coordinators during the quarterly Medical Record Reviews, with results reported to the Chief of Staff.

Recommendation 7. We recommended that designated employees receive annual N95 fit testing, as required.

Concur

Target date for completion: August 31, 2010

The N95 Fit testing and respirator training in progress for designated employees. The N95 fit testing and respirator training will be completed by August 31, 2010. Future N95 fit testing and respirator training will be conducted annually by the Safety Department.

Recommendation 8. We recommended that monitoring results be reported quarterly to the MSEC, as required.

Concur

Target date for completion: July 1, 2010

Monitoring of initial and ongoing competency validation, compliance with SOPs, results of infection prevention monitoring, and risk management activities associated with RME will be done by the Infection Control Committee. Results will be reported quarterly to the MSEC by the Infection Control Preventionist.

OIG Contact and Staff Acknowledgments

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