Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 10-00052-10

Combined Assessment Program Review of the VA Gulf Coast Veterans Health Care System Biloxi, Mississippi

October 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 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

BLS	Basic Life Support
C&P	credentialing and privileging
CAP	Combined Assessment Program
CBOC	community based outpatient clinic
CEB	Clinical Executive Board
CLC	community living center
CNH	contract nursing home
COC	coordination of care
CPRS	Computerized Patient Record System
DOD	Department of Defense
ED	emergency department
EOC	environment of care
facility	VA Gulf Coast Veterans Health Care System
FPPE	Focused Professional Practice Evaluation
FTE	full-time employee equivalents
FY	fiscal year
IC	infection control
ICU	intensive care unit
JC	Joint Commission
MH	mental health
MSIT	Multidisciplinary Safety Inspection Team
NFPA	National Fire Protection Association
OIG	Office of Inspector General
OPPE	Ongoing Professional Practice Evaluation
OSHA	Occupational Safety and Health Administration
PI	performance improvement
PR	peer review
QM	quality management
RCA	root cause analysis
RME	reusable medical equipment
SOP	standard operating procedure
SPD	Supply, Processing, and Distribution
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

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Executive Summary: Combined Assessment Program Review of the VA Gulf Coast Veterans Health Care System, Biloxi, MS

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 August 2, 2010.

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

- Coordination of Care
- Medication Management
- Physician Credentialing and Privileging
- Suicide Prevention Safety Plans

The facility's reported accomplishments included System Redesign Team successes with improving clinic utilization and managing difficult discharges and a successful relationship with Department of Defense partners.

Recommendations: We made recommendations in the following three activities:

Quality Management: Ensure that all peer review extensions have the Director's approval in writing. Implement a local policy governing copy and paste entries in the medical record. Implement a process to monitor compliance with Basic Life Support training, and revise local policy to include consequences for not maintaining certification.

Environment of Care: Require multi-dose vials in the emergency department to be dated and initialed when opened. Ensure that environment of care rounds include participation by required team members. Ensure that members of the Multidisciplinary Safety Inspection Team and acute locked inpatient mental health unit employees receive required training.

Reusable Medical Equipment: Report results of monitoring reusable medical equipment processes to the Clinical Executive Board quarterly.

Comments

The Veterans Integrated Service Network and Facility Directors agreed with the Combined Assessment Program review findings and recommendations 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 2009 and FY 2010 through August 2, 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 VA Gulf Coast Veterans Health Care System, Biloxi, Mississippi, Report No. 07-00161-159, July 2, 2007). The facility had corrected all findings from the previous CAP review, and we consider these issues closed.

During this review, we also presented crime awareness briefings for 617 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

VA/DOD Sharing Agreements

There are four DOD medical care facilities within close proximity to the facility, and the facility has a unique relationship with its DOD partners (Keesler, Eglin, and Tyndall Air Force Medical Groups and the Pensacola Naval Hospital) to share inpatient and outpatient services. This allows veterans access to services that would be cost prohibitive to provide with VA resources alone. An integrated management and governance group, known as the Executive Management Team, provides oversight for strategic planning and coordinating VA/DOD services throughout the Gulf Coast. Sharing services increases the scope of services and the availability of appointments for veterans and also provides DOD clinicians with a larger volume of more complex patients, enhancing their residency training programs.

Difficult Discharges

Patients who remain in the hospital beyond medical necessity adversely affect patient flow and increase health care costs. Patients who were difficult to discharge were being "boarded" due to lack of transportation, community resources, or appropriate placement options. A Systems Redesign Team was formed to address the situation. Over the course of 6 months, the avoidable bed days of care were reduced by 47 percent, and cost avoidance is estimated at $927,272 per year.

Clinic Utilization

The clinic utilization rate was 40 percent in November 2009. An interdisciplinary Systems Redesign Team was developed to review clinic appointment structure and identify opportunities for improved access to care. Service chiefs

and administrative officers worked with the team, and clinic access and utilization reports were presented to facility leadership on a weekly basis. Within 9 months, the clinic utilization rate increased to 78 percent.

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 Chief of Staff, 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 conditions that needed improvement.

PR. VHA policy[1] requires written approval by the facility Director for an extension on any PR that exceeds the 120-day deadline for completion. During the 4th quarter of FY 2009 and the 1st quarter of FY 2010, we found a total of 12 peer reviews that were not completed within 120 days, and none of the 12 had the Director's written approval for extension. The facility has recently implemented a new process to improve timeliness.

Medical Records. VHA policy[2] requires a local policy and process for ongoing review of medical record copy and paste entries. Medical record reviews during the 1st and 2nd quarters of FY 2010 showed that numerous services used the copy and paste function inappropriately, and actions had not been taken to address deficiencies. We also found that the facility did not have a local policy in place, as required.

BLS. VHA policy[3] requires a local policy and process to ensure timely renewal of BLS certification and requires actions to be taken for noncompliance. The facility did not

[1] VHA Directive 2008-004, *Peer Review for Quality Management*, January 28, 2008.
[2] VHA Handbook 1907.01, *Health Information Management and Health Records*, August 25, 2006.
[3] VHA Directive 2008-008, *Cardiopulmonary Resuscitation (CPR) and Advanced Cardiac Life Support (ACLS) Training for Staff*, February 6, 2008.

have a process for monitoring employees required to maintain BLS certification; therefore, we were unable to determine current compliance rates. We also found that local policy did not address consequences for failure to comply with training requirements.

Recommendations

1. We recommended that the Director approve all PR extensions in writing, as required.

2. We recommended that a local policy regarding the appropriate use and monitoring of copy and paste entries in medical records be implemented, as required.

3. We recommended that the facility implement a process to monitor BLS training compliance and that local policy include consequences for not maintaining certification.

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 EOC program that fully meets VHA, National Center for Patient Safety, OSHA, NFPA, and JC standards.

We inspected the acute locked inpatient MH unit, the medical/surgical/telemetry unit, the ICU, the post-anesthesia care unit, the ambulatory surgical outpatient unit, the ED, the women's clinic, the dental clinic, two CLC units, and three primary care clinics. The facility maintained a generally clean and safe environment.

The IC program appropriately aggregated and analyzed hand hygiene data for PI. In addition, the data was reported to the IC Committee, as required. Also, the facility had a comprehensive IC Risk Assessment and Action Plan to address high-risk areas by implementing appropriate actions.

We determined that all selected employees from Radiology Service, bronchoscopy, the medical/surgical/telemetry unit, the ICU, the ED, and the operating room had received annual N95[4] fit testing for FY 2009, as required by OSHA. In addition, all selected employees from Nursing, Medicine, and Environmental Management Services had completed the OSHA required annual bloodborne pathogens training for FY 2009. Also, the facility had conducted fire drills once per shift per quarter in each building designated for health care

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

occupancy, as required by NFPA regulations and JC standards.

VHA[5] requires that furnishings in patient care areas of locked inpatient MH units be physically heavy or secured to the floor to prevent them from being moved, overturned, thrown, or used as weapons. In the restraint room on the acute locked inpatient MH unit, we found a lightweight bed that was not secured to the floor. This bed is used for combative patients who require leather restraints. Staff and patients were at risk for injury while trying to manage the patient and place restraints and, at the same time, control the position of the bed. Managers took immediate action while we were onsite and secured the bed to the floor.

We also found that the door of the seclusion room on the acute locked inpatient MH unit had a spring activated lock system that prevented the door from opening from the inside. This posed the risk that staff could be trapped inside the room. During our site visit, managers replaced the lock with a manual dead bolt that does not automatically lock when the door is closed. Since these conditions were corrected while we were onsite, we made no recommendations related to these findings. However, we identified the following conditions that needed improvement.

Security of Medications. Local policy requires that multi-dose vials be dated and initialed when opened and then discarded 28 days from the opening date. We found two open, undated multi-dose vials of insulin in the ED. Managers immediately discarded the vials.

Environmental Rounds. VHA policy[6] requires that weekly EOC rounds led by the Director or Associate Director include participation by managers in nursing, building management, engineering, and safety; representatives from patient safety and IC; and others, as required. We reviewed attendance records for EOC rounds during the 2nd and 3rd quarters of FY 2010 and found that nursing, the Director's office, and information security were not consistently represented.

[5] VHA National Center for Patient Safety, "Mental Health Environment of Care Checklist," April 8, 2010.
[6] Deputy Under Secretary for Health for Operations and Management, "Environmental Rounds," memorandum, March 5, 2007.

Training. VHA policy[7] requires employees of locked inpatient MH units and members of the MSIT to complete training on environmental hazards that represent a threat to suicidal patients. This training should occur initially during orientation and annually thereafter. We reviewed training records and found that 7 (35 percent) of 20 selected employees from the acute locked inpatient MH unit and members of the MSIT had not completed initial or annual training, as required.

Recommendations

4. We recommended that ED multi-dose vials be dated and initialed when opened, as required.

5. We recommended that EOC rounds include participation by all required team members or their representatives.

6. We recommended that acute locked inpatient MH unit employees and members of the MSIT receive required training on environmental hazards that represent a threat to suicidal patients.

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 a safe environment. The facility's SPD area is required to meet VHA, Association for the Advancement of Medical Instrumentation, OSHA, and JC standards.

We inspected the SPD, hemodialysis, and operating room areas. We noted that traffic in the SPD areas was restricted to authorized personnel and that appropriate personal protective equipment was donned prior to entering the SPD reprocessing areas, as required. We also noted that appropriate infection prevention controls were in place and that 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 two employees who demonstrated cleaning procedures and found that annual competencies and training were current and consistently documented.

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

We reviewed the SOPs for reprocessing for five pieces of RME. We found that three of the five SOPs were well developed and consistent with the manufacturers' instructions. While we were onsite, minor changes were made to two SOPs to reflect actual practice and be consistent with manufacturers' guidelines. Therefore, we made no recommendation for this finding.

For maximum effectiveness and safety, VA requires[8] that manufacturers' instructions for cleaning solutions used in reprocessing RME be followed. We found a sink in the operating room 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 condition that needed improvement.

Reporting of Monitoring Results. VHA[9] 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 and that results be reported to the CEB quarterly. We found that infection prevention monitoring was in place. The IC Coordinator and the Chief of SPD had developed and implemented an innovative process to monitor staff competence and the appropriateness of SOPs periodically and to identify opportunities for improvement. Monitoring results were tracked, trended, and reported to the SPD Committee; however, results were not reported to the CEB, as required.

Recommendation

7. We recommended that results of monitoring RME processes be reported quarterly to the CEB, as required.

Review Activities Without Recommendations

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.

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

VHA[10] requires that facilities have a policy that ensures the safe, appropriate, and timely transfer of patients and that transfers are monitored and evaluated as part of the QM program. We determined that the facility had an appropriate transfer policy and that acceptable monitoring was in place.

VHA requires specific information (such as the reason for transfer and services required) to be recorded in the transfer documentation. We reviewed transfer documentation for 10 patients transferred from the facility's acute inpatient units or the ED to another facility. We determined that clinicians generally documented required elements; however, we did not find documentation that advance directives were addressed prior to transfer for any of the 10 patients.

In July 2010, the facility revised the template used for documentation of patient transfers to include an advance directive element. We reviewed documentation for an additional eight patients transferred after this revision and found that advance directives were addressed for all eight patients. Therefore, we made no recommendation for this finding.

VHA policy[11] and JC standards require that providers include information regarding medications, diet, activity level, and follow-up appointments in written patient discharge instructions and that patients receive a copy of their instructions. We reviewed the medical records of 10 discharged patients and determined that clinicians had generally documented the required elements. One record had no documentation that the patient received a copy of the discharge instructions. However, we made no recommendations.

Medication Management

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

The facility did not have a practice guideline in place governing the maintenance of chronic renal disease patients who receive erythropoiesis-stimulating agents. However, we found that clinical staff had appropriately identified and addressed elevated hemoglobin levels in all six patients

[10] VHA Directive 2007-015, *Inter-Facility Transfer Policy*, May 7, 2007.
[11] VHA Handbook 1907.01.

whose medical records we reviewed. In general, influenza vaccinations were documented adequately for CLC residents, and clinical staff documented appropriately if vaccines were not administered. Also, the facility had pharmacy services available 24 hours a day, 7 days a week. 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.[12] We also reviewed meeting minutes during which discussions about the physicians took place.

We reviewed 10 C&P files and profiles and found that all licenses were current and that the facility had obtained primary source verification. 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 found only one physician profile that was not completed; however, the required documentation was in the C&P file. 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.[13]

[12] VHA Handbook 1100.19, *Credentialing and Privileging,* November 14, 2008.
[13] Deputy Under Secretary for Health for Operations and Management, "Patients at High-Risk for Suicide," memorandum, April 24, 2008.

A previous OIG review of suicide prevention programs in VHA facilities[14] found a 74 percent compliance rate with safety plan development. The safety plan issues identified in 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. We found that clinicians had developed timely safety plans in 9 (90 percent) of the 10 records reviewed. Documentation that the patient received a copy of the safety plan was found in three of the nine safety plans reviewed. All other required elements were included in the safety plans.

While we were onsite, the safety plan template was revised to include documentation that the patient received a copy of the safety plan and that the patient and/or his/her family participated in the development of the plan. Therefore, 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 D and E, pages 15–19, for the full text of the Directors' comments.) We will follow up on the planned actions until they are completed.

[14] *Healthcare Inspection – Evaluation of Suicide Prevention Program Implementation in Veterans Health Administration Facilities January–June, 2009;* Report No. 09-00326-223; September 22, 2009.

Facility Profile[15]		
Type of Organization	Secondary medical center	
Complexity Level	2	
VISN	16	
CBOCs	Mobile, AL Pensacola, FL Eglin AFB, FL Panama City, FL	
Veteran Population in Catchment Area	244,997	
Type and Number of Total Operating Beds: • **Hospital, including Psychosocial Residential Rehabilitation Treatment Program**	63	
• **CLC/Nursing Home Care Unit**	101	
• **Other**	34 (post-traumatic stress disorder = 17, substance abuse = 17)	
Medical School Affiliation(s)	Tulane University University of South Alabama Florida State University	
• **Number of Residents**	86	
	FY 2010 (through May 2010)	**FY 2009**
Resources (in millions):		
• **Total Medical Care Budget**	$308.2	$209.1
• **Medical Care Expenditures**	$316	$298.7
Total Medical Care FTE	1,763	1,771
Workload:		
• **Number of Unique Patients**	52,442	56,100
• **Inpatient Days of Care:**		
o **Acute Care**	10,389	15,794
o **CLC/Nursing Home Care Unit**	18,711	28,186
Hospital Discharges	1,526	2,311
Total Average Daily Census (including all bed types)	149	147
Cumulative Occupancy Rate	75%	74%
Outpatient Visits	358,576	517,474

[15] All data provided by facility management.

Follow-Up on Previous Recommendations			
Recommendations	**Current Status of Corrective Actions Taken**	**In Compliance Y/N**	**Repeat Recommendation? Y/N**
QM			
Accurately reconcile medications during admission, transfer, and discharge for all services indicated.	Monthly audits were initiated in 2007, and Pharmacy Service continues to monitor medication reconciliation practices. Results of monitoring are reported to appropriate committees. Software was added to CPRS to enhance the process. Education is ongoing.	Y	N
Conduct and complete RCAs as required. Implement RCA actions and monitor outcomes as required.	RCAs are completed, actions are implemented, and outcomes are monitored appropriately.	Y	N
Define all future Level 3 peer reviews to be consistent with VHA policy.	Local PR policy was revised, and a standardized PR form was put into place. The PR Level 3 definition is now consistent with VHA policy.	Y	N
CNH			
Complete CNH inspections within the timeframe required.	Eleven of 12 scheduled reviews have taken place since 2007.	Y	N
Integrate CNH PI activities into the facility's QM program.	A QM representative has been a member of the CNH Oversight Committee since 2007. PI activities are ongoing, and results are reported to the Clinical Standards Committee and the CEB.	Y	N

CPRS Business Rules			
Assure that signed progress notes cannot be edited or deleted.	CPRS software patch 1.0*234 was installed in February 2008.	Y	N
EOC			
Repair roof and air conditioning units.	New roofing was installed throughout the campus, and fan coils and air conditioning systems have been updated and replaced.	Y	N

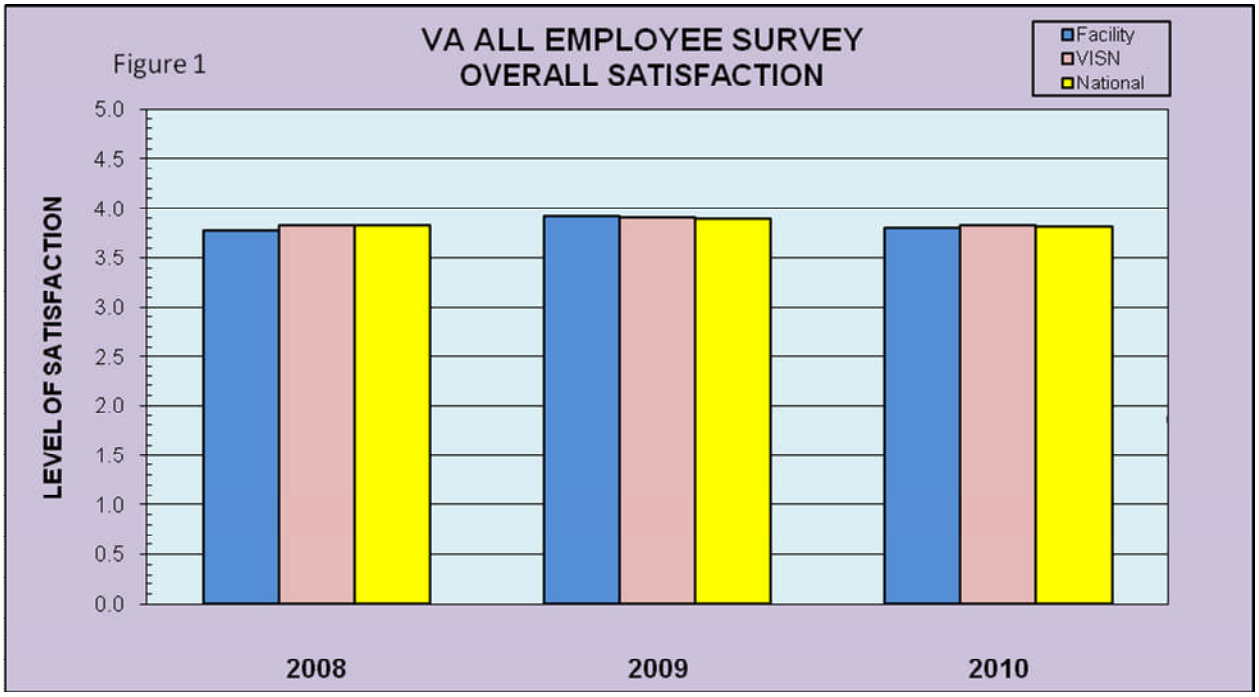
VHA Satisfaction Surveys

VHA has identified patient and employee satisfaction scores as significant indicators of facility performance. Patients are surveyed monthly. VHA is currently in the process of transitioning to the Consumer Assessment of Healthcare Providers and Systems survey. As a result, data for FY 2009 have been summarized for the entire year. Table 1 below shows facility, VISN, and VHA calibrated overall inpatient and outpatient satisfaction scores for FY 2009 and overall inpatient and outpatient satisfaction scores and targets for the 1st and 2nd quarters of FY 2010.

Table 1

	FY 2009		FY 2010 (inpatient target = 64; outpatient target = 56)			
	Inpatient Score	Outpatient Score	Inpatient Score Quarter 1	Inpatient Score Quarter 2	Outpatient Score Quarter 1	Outpatient Score Quarter 2
Facility	74.57	53.22	68.2	66.7	54.2	53.0
VISN	65.00	47.87	66.1	64.6	53.1	54.3
VHA	65.01	52.87	63.3	63.9	54.7	55.2

Employees are surveyed annually. Figure 1 below shows the facility's overall employee scores for 2008, 2009, and 2010. 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: October 1, 2010

From: Director, South Central VA Health Care Network (10N16)

Subject: **CAP Review of the VA Gulf Coast Veterans Health Care System, Biloxi, MS**

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

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

Attached is the completed response for the CAP review of The VA Gulf Coast Veterans Health Care System, Biloxi, Mississippi. If you have any questions regarding the report, please contact Mary Jones a 601-206-6974.

George H. Gray, Jr.

Network Director

Facility Director Comments

Department of Veterans Affairs **Memorandum**

Date: September 27, 2010

From: Director, VA Gulf Coast Veterans Health Care System (520/00)

Subject: **CAP Review of the VA Gulf Coast Veterans Health Care System, Biloxi, MS**

To: Director, South Central VA Health Care Network (10N16)

1. I have reviewed the OIG CAP report and attached you will find my comments.
2. Questions should be referred to me at 228-523-5766.

Thomas Wisnieski

Thomas Wisnieski, MPA, 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 Director approve all PR extensions in writing, as required.

Concur

Target date for completion: December 31, 2010

Plan: The peer review electronic tracking system will be utilized to ensure peer reviews are completed within 120 days. Those peer reviews at 90 days or greater will receive weekly communication regarding updates and target completion dates. Peer Reviews that are anticipated to go beyond 120 days will be submitted to the Director for approval. The submittal will include an explanation for the delay and the targeted completion date. A compliance rate benchmark of 90 percent has been established. Peer Reviews will be monitored by the Risk Manager, Medical & Legal Affairs. Monthly updates will be provided to Quality & Performance Management Board and the Peer Review Committee.

Recommendation 2. We recommended that a local policy regarding the appropriate use and monitoring of copy and paste entries in medical records be implemented, as required.

Concur

Target date for completion: December 31, 2010

Plan: A new station memorandum entitled "Copying, Pasting, and Template Use" was approved for distribution on August 5, 2010. As part of the implementation plan, the Chief, Health Information Management Section (HIMS) will educate clinical services (e.g., Medicine, Surgery) and clinical personnel (e.g., physicians, nurses) on the new policy and clearly outline inappropriate criteria for the use of copying and pasting. The Chief, HIMS will audit a minimum of 40 charts per month to determine compliance with established criteria. A compliance rate benchmark of 90 percent has been established. Results of the audits will be reported to the clinical service chiefs for appropriate action, as well as the Medical Records Committee and the Clinical Executive Board.

Recommendation 3. We recommended that the facility implement a process to monitor BLS training compliance and that local policy include consequences for not maintaining certification.

Concur

Target date for completion: January 31, 2011

Plan: A policy addressing BLS/ACLS training and compliance, including consequences for noncompliance, will be drafted and submitted to the Director. The Chief, Medical Service will be responsible for this process. This policy will outline all training requirements, training and tracking responsibilities and consequences for clinical staff who fail to maintain current BLS/ACLS certification. A compliance rate benchmark of 90 percent has been established. Monthly reports of training and compliance will be provided to the Critical Care Committee, the Clinical Standards Committee and the Clinical Executive Board.

Recommendation 4. We recommended that ED multi-dose vials be dated and initialed when opened, as required.

Concur

Target date for completion: November 15, 2010

Plan: Medication checks in the Emergency Department will be revised to assure compliance. Multi-dose vials will be initialed and dated when opened, with a 28-day expiration date for disposal. During narcotic medication counts, the Emergency Department Registered Nurse will check all multi-dose vials for expiration dates and discard if necessary. A compliance rate benchmark of 90 percent has been established. Tracking of compliance will be the responsibility of the Emergency Department Nurse Manager or designee. Reporting of compliance will be made to the Quality and Performance Management Board and the Pharmacy & Therapeutics Committee.

Recommendation 5. We recommended that EOC rounds include participation by all required team members or their representatives.

Concur

Target date for completion: December 1, 2010

Plan: The environmental rounds program station memorandum has been updated. The new policy will reflect changes in team membership in accordance with requirements outlined in the March 5, 2007 VHA letter concerning Environmental Rounds. Training has been scheduled on the Environmental Rounds process for September 28, 2010, with new Pentad members and their representatives. A compliance rate benchmark of 90 percent participation by all team members, or designee when appropriate, has been established. The monitoring of attendance for required participants will be the

responsibility of the Safety Officer. Attendance results will be reported bi-weekly to the Associate Director. Results will also be reported monthly to the Environment of Care Committee and the Administrative Executive Board.

Recommendation 6. We recommended that acute locked inpatient MH unit employees and members of the MSIT receive required training on environmental hazards that represent a threat to suicidal patients.

Concur

Target date for completion: December 1, 2010

Plan: All employees assigned to the Mental Health Inpatient Unit will complete required training for suicide risk management upon unit orientation and annually thereafter. Annual training will be completed by November 30 of each fiscal year. A compliance rate benchmark of 90 percent has been established. Monitoring of education completion will be the responsibility of the Chief, Psychiatry or designee. Results of the compliance monitor will be reported to the Patient Safety Committee, the Mental Health Executive Committee, and the Clinical Executive Board.

Recommendation 7. We recommended that results of monitoring RME processes be reported quarterly to the CEB, as required.

Concur

Target date for completion: October 31, 2010

Plan: Required RME monitors will be tracked on a monthly basis. Results will be trended and analyzed, with findings reported monthly to the RME Committee. In addition, the reporting of outcomes will be added as a standing agenda item for review by the Clinical Executive Board. Reporting and compliance will be the responsibility of the Associate Director Patient Care Services, or designee.

OIG Contact and Staff Acknowledgments

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Report Distribution

VA Distribution

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Non-VA Distribution

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