
**Department of Veterans Affairs**
**Office of Inspector General**

**Office of Healthcare Inspections**

**Report No. 10-02980-50**

# Combined Assessment Program Review of the VA Boston Healthcare System Boston, Massachusetts

**December 22, 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

| | |
|---|---|
| *C. difficile* | *Clostridium difficile* |
| C&P | credentialing and privileging |
| CAP | Combined Assessment Program |
| CBOC | community based outpatient clinic |
| CHF | congestive heart failure |
| CLC | community living center |
| COC | coordination of care |
| CPR | cardiopulmonary resuscitation |
| CPRS | Computerized Patient Record System |
| CS | controlled substance |
| EOC | environment of care |
| facility | VA Boston Healthcare System |
| FPPE | Focused Professional Practice Evaluation |
| FTE | full-time employee equivalents |
| FY | fiscal year |
| IC | infection control |
| MDRO | multidrug-resistant organisms |
| MH | mental health |
| MICU | medical intensive care unit |
| OIG | Office of Inspector General |
| OPPE | Ongoing Professional Practice Evaluation |
| PRC | Peer Review Committee |
| PRRTP | Psychosocial Residential Rehabilitation Treatment Program |
| PSB | Professional Standards Board |
| QM | quality management |
| SARRTP | Substance Abuse Residential Rehabilitation Treatment Program |
| SOPs | standard operating procedures |
| VHA | Veterans Health Administration |
| VISN | Veterans Integrated Service Network |

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# Executive Summary: Combined Assessment Program Review of the VA Boston Healthcare System, Boston, MA

**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 October 18, 2010.

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

- Management of Multidrug-Resistant Organisms
- Management of Test Results
- Medication Management

The facility reported as accomplishments the reduction in hospital-acquired *Clostridium difficile* infections and the reduction of hospital-acquired pressure ulcers.

**Recommendations:** We made recommendations in the following four activities:

*Environment of Care:* Facility managers should conduct an assessment to identify issues with crash carts and emergency kits throughout the facility and take corrective actions as necessary.

*Quality Management:* All quality management committees should document and track implementation and closure of action items and include a method to track issues to completion. Peer Review Committee minutes should contain detailed discussions of peer reviews and documentation of completed corrective actions taken on Level 3 peer reviews.

*Physician Credentialing and Privileging:* Clinical managers should fully develop professional practice evaluations for all physicians, and Professional Standards Board meeting minutes should reflect discussions of performance data prior to granting requested privileges or reprivileging.

*Coordination of Care:* Staff should provide patients with written advance directive notification and correctly record advance directive status at each inpatient admission.

## 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

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

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
- Management of MDRO
- Management of Test Results
- Medication Management
- Physician C&P
- QM

The review covered facility operations for FY 2009 and FY 2010 through August 31, 2010, and was done in accordance with OIG SOPs for CAP reviews. We also followed up on recommendations from our prior CAP review of the facility (*Combined Assessment Program Review of the VA Boston Healthcare System, Boston, Massachusetts,*

Report No. 07-03172-114, April 21, 2008). The facility had corrected all findings from our previous review.

During this review, we also presented crime awareness briefings for 62 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

## Reduced Rate of *C. difficile* Infections

In November 2004, staff observed a significant increase in the rates of hospital-acquired *C. difficile* infections.[1] Three months later, a team comprised of staff from Environmental Services, administration, nursing, IC, and pharmacy conducted an intensive analysis to evaluate the interdisciplinary delivery of care to patients infected with *C. difficile.*

The team designed and implemented strategies to reduce the rate of infection. Strategies included early diagnosis, strict management of antibiotic use, special contact precautions, and a review of cleaning and disinfection procedures. The implemented strategies resulted in a 50 percent decrease in the infection rate over the next 4 years. In addition, between 2009 and 2010, the facility realized an estimated cost savings of $87,500 due to decreased bed days of care.

## Reduction in Hospital-Acquired Pressure Ulcers

Nursing Service, in conjunction with the Interdisciplinary Skin Care Committee, developed protocols and strategies to reduce hospital-acquired pressure ulcers. Strategies for pressure ulcer prevention included nursing staff education on identifying patients at risk for skin breakdown, wound assessment, wound staging,[2] and care options. Also, during FY 2010, the wound care specialist implemented protocols for heel and sacrooccygeal[3] care. As a result,

[1] *C. difficile* is a bowel bacteria most frequently identified in patients with antibiotic hospital-acquired diarrhea.

[2] Wound staging describes the severity of the wound and helps determine how to treat it.

[3] Sacrococcygeal pertains to both the sacrum (large, heavy bone at the base of the spine) and the coccyx (small tail-like bone at the base of the spine).

hospital-acquired pressure ulcers decreased from 155 ulcers in FY 2009 to 96 ulcers in FY 2010—a 38-percent decrease.

# Results

## Review Activities With Recommendations

**EOC**

The purpose of this review was to determine whether the facility maintained a safe and clean health care environment in accordance with applicable requirements.

We inspected the following patient care areas:

- West Roxbury division
  - One medical unit
  - One surgical unit
  - The spinal cord injury unit
  - The MICU
  - The emergency department
  - The radiology department
  - The pulmonary clinic
  - One specialty clinic
- Brockton division
  - One acute MH unit
  - The CLC
  - The SARRTP
  - The radiology department
  - The urgent care department
  - The dental clinic
- Jamaica Plain division
  - The SARRTP
  - The women's clinic
  - The MH clinic
  - The radiology department

The facility maintained a generally clean and safe environment. However, we identified the following area that needed improvement.

Emergency Crash Carts. VHA policy requires oversight of the equipment maintained on emergency crash carts and in

emergency response kits.[4,5] After finding an unlocked crash cart, we inspected 12 carts and 2 emergency response kits. We found deficiencies in nine (75 percent) of the carts. Five carts contained expired disposable medical supplies, two carts contained laryngoscopes that were in need of repair, and two carts had control tags with serial numbers that did not match the corresponding numbers on the carts' daily checklists. We also found deficiencies in expiration dates of the two emergency response kits we inspected. For one kit, the external expiration date did not correspond with the contents inside, and for the other kit, the expiration date was missing from the daily checklist. In addition, one kit also contained a laryngoscope that was in disrepair.

**Recommendation**

**1.** We recommended that facility managers conduct an assessment to identify issues with crash carts and emergency kits throughout the facility and take corrective actions as necessary.

## QM

The purpose of this review was to evaluate whether the facility had a comprehensive QM program in accordance with applicable requirements and whether senior managers actively supported the program's activities.

We interviewed senior managers and QM personnel, and we evaluated policies, meeting minutes, and other relevant documents. We identified the following areas that needed improvement.

QM Committees. VHA requires each facility to establish a leadership committee to review QM data and ensure the discussion of key components.[6] Once QM data are analyzed and trended and actions are determined, implementation of actions is to be followed to completion. Committee minutes must include discussions about QM reviews and reflect tracking of issues to completion. We found that senior-level QM Committee, Moderate Sedation Committee, PRC, and CPR Committee minutes did not consistently document and track the implementation and closure of action items and did not include a method to track issues to completion.

[4] VHA Directive 2008-063, *Oversight and Monitoring of Cardiopulmonary Resuscitative Events and Facility Cardiopulmonary Resuscitation Committees*, October 17, 2008.
[5] Emergency kits include an "orange bag" containing crash cart items carried by Brockton division urgent care staff responding to events outside of their unit and medication kits on each unit that contain medications for treating acute coronary syndrome.
[6] VHA Directive 2009-043, *Quality Management System*, September 11, 2009.

Peer Review. VHA policy requires that PRC meeting minutes include detailed peer review discussions.[7] VHA policy further requires that the PRC document completed corrective actions when a Level 3 peer review results in actions. We found that PRC minutes did not reflect detailed discussion of peer reviews or any completed actions taken on Level 3 peer reviews.

**Recommendations**

**2.** We recommended that all QM committees consistently document and track the implementation and closure of action items and include a method to track issues to completion.

**3.** We recommended that PRC minutes contain detailed discussions of peer reviews and documentation of completed corrective actions taken on Level 3 peer reviews.

## Physician C&P

The purpose of this review was to determine whether the facility had consistent processes for physician C&P that complied with applicable requirements.

We reviewed 21 physicians' C&P files and profiles and found that licenses were current and that primary source verification had been obtained. However, we identified the following area that needed improvement.

Professional Practice Evaluations. VHA policy requires specific competency criteria for FPPE and OPPE for all privileged physicians.[8] Although clinical managers had developed criteria for practice evaluations, at the time of our review, full implementation was not in place for all physicians. As a result, we did not find FPPEs for five of the eight newly hired physicians who required them. In addition, PSB meeting minutes did not reflect detailed discussions of physicians' performance data prior to granting privileges or reprivileging, as required by VHA policy.

**Recommendation**

**4.** We recommended that clinical managers fully develop professional practice evaluations for all physicians and that PSB meeting minutes reflect discussions regarding performance data prior to granting requested privileges or reprivileging.

[7] VHA Directive 2008-004, *Peer Review for Quality Management*, January 28, 2008.
[8] VHA Handbook 1100.19, *Credentialing and Privileging*, November 14, 2008.

**COC**

The purpose of this review was to evaluate whether the facility managed advance care planning, advance directives, and discharges in accordance with applicable requirements.

We reviewed patients' medical records for evidence of advance care planning, advance directives, and discharge instructions. We identified the following areas that needed improvement.

Advance Directive Notification. VHA requires that patients receive written notification at each admission to a VHA inpatient facility stating their right to accept or refuse medical treatment, to designate a Health Care Agent, and to document their treatment preferences in an advance directive.[9] We reviewed the medical records of 12 patients and found evidence of written notification in only 2 (17 percent) of the records.

Advance Directive Screening. VHA requires that facility staff ask patients whether they have advance directives and document the screening in the medical record.[10] For 3 (25 percent) of 12 records reviewed, we found that facility staff did not correctly document advance care status during screening.

**Recommendation**

**5.** We recommended that facility managers implement procedures to ensure that staff provide patients with written advance directive notification and correctly record advance directive status at each inpatient admission.

## Review Activities Without Recommendations

**Management of MDRO**

The purpose of this review was to evaluate whether the facility had developed a safe and effective program to reduce the incidence of MDRO in its patient population in accordance with applicable requirements.

We reviewed the facility's IC risk assessment, employee training records, and medical records. We inspected the MICU at the West Roxbury division and the CLC at the Brockton division, and we interviewed employees. We determined that the facility had an effective program in place. We made no recommendations.

[9] VHA Handbook 1004.02, *Advance Care Planning and Management of Advance Directives*, July 2, 2009.
[10] VHA Handbook 1004.02.

## Management of Test Results

The purpose of this review was to follow up on a previous OIG review that identified improvement opportunities related to documentation of notification of abnormal test results and follow-up actions taken.[11]

We reviewed the facility's policies and procedures, the process for monitoring communication of test results, and the medical records of patients who had tests resulting in critical values and normal values. We determined that the facility had implemented an effective reporting process for critical test results.

VHA requires facilities to communicate normal results to patients no later than 14 calendar days from the date that the results are available to the ordering provider.[12] We reviewed the medical records of 20 patients who had normal results and found that only 9 (45 percent) records contained documented evidence of notification; however, managers had previously identified the issue and had instituted measures to increase compliance that resulted in clear improvement. Therefore, we made no recommendations.

## Medication Management

The purpose of this review was to determine whether the facility employed safe practices in the preparation, transport, and administration of hazardous medications, specifically chemotherapy, in accordance with applicable requirements.

We observed the compounding and transportation of chemotherapy medications and the administration of those medications in the oncology clinic, and we interviewed employees. We determined that the facility safely prepared, transported, and administered the medications. 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 13–17, for the full text of the Directors' comments.) We will follow up on the planned actions until they are completed.

[11] *Healthcare Inspection Summary Review – Evaluation of Veterans Health Administration Procedures for Communicating Abnormal Test Results,* Report No. 01-01965-24, November 25, 2002.
[12] VHA Directive 2009-019, *Ordering and Reporting Test Results*, March 24, 2009.

| Facility Profile[13] | | |
|---|---|---|
| **Type of Organization** | Tertiary care medical center | |
| **Complexity Level** | 1a | |
| **VISN** | 1 | |
| **CBOCs** | Worcester, MA<br>Lowell, MA<br>Quincy, MA<br>Framingham, MA<br>Boston, MA | |
| **Veteran Population in Catchment Area** | 66,230 | |
| **Type and Number of Total Operating Beds:**<br>• **Hospital, including PRRTP** | 541 | |
| • **CLC/Nursing Home Care Unit** | 160 | |
| **Medical School Affiliations** | Harvard University<br>Boston University | |
| • **Number of Residents** | 1,230 | |
| | **Current FY (through September 2010)** | **Prior FY** |
| **Resources (in millions):** | | |
| • **Total Medical Care Budget** | $427.8 | $398.5 |
| • **Medical Care Expenditures** | $362 | $399 |
| **Total Medical Care FTE** | 2,408.3 | 2,354.2 |
| **Workload:** | | |
| • **Number of Station Level Unique Patients** | 57,401 | 53,872 |
| • **Inpatient Days of Care:** | | |
| o **Acute Care** | 96,022 | 98,396 |
| o **CLC/Nursing Home Care Unit** | 45,395 | 41,882 |
| **Hospital Discharges** | 17,252 | 15,965 |
| **Total Average Daily Census (including all bed types)** | 482.3 | 483.2 |
| **Cumulative Occupancy Rate** | 75.6% | 76.9% |
| **Outpatient Visits** | 739,180 | 684,091 |

[13] 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** |
| **Pharmacy Operations** | | | |
| 1. Appoint CS inspectors in writing and ensure that appointment letters are retrievable. | CS inspectors are appointed in writing, and appointment letters are available for inspection. | Y | N |
| 2. Ensure that CS inspectors validate two CS transfers during monthly inspections. | Two CS transfers are validated during monthly inspections. | Y | N |
| 3. Ensure that CS inspectors verify change of shift counts for non-automated dispensing units and weekly inventories of the automated unit during monthly inspections. | Change of shift counts for non-automated dispensing units and weekly inventories of the automatic units during monthly inspections are being documented. | Y | N |
| 4. Ensure that CS inspectors reconcile 1 day's dispensing from the pharmacy to the automated unit during monthly inspections. | One day's reconciliation from the automated dispensing units is documented during monthly inspections. | Y | N |
| 5. Ensure that quarterly CS inspection reports are submitted to the facility's Director. | The facility Director receives monthly CS inspection reports. | Y | N |
| **EOC** | | | |
| 6. Ensure that Engineering Service and safety managers inspect all portable fire extinguishers monthly. | All portable fire extinguishers have documentation of monthly inspection. | Y | N |

| Recommendations | Current Status of Corrective Actions Taken | In Compliance Y/N | Repeat Recommendation? Y/N |
|---|---|---|---|
| 7. Ensure that Engineering Service managers inspect the wander alert systems annually and establish a log of maintenance and repairs. | The Chief of Engineering Service established a system for annual inspection of the wander alert system and now maintains a log of maintenance and repairs. | Y | N |
| **CPRS Business Rules** | | | |
| 8. Review CPRS business rules regularly to ensure compliance with VHA regulations and local policy | CPRS business rules are reviewed semiannually, and results are reported to the Medical Records Review Committee. | Y | N |

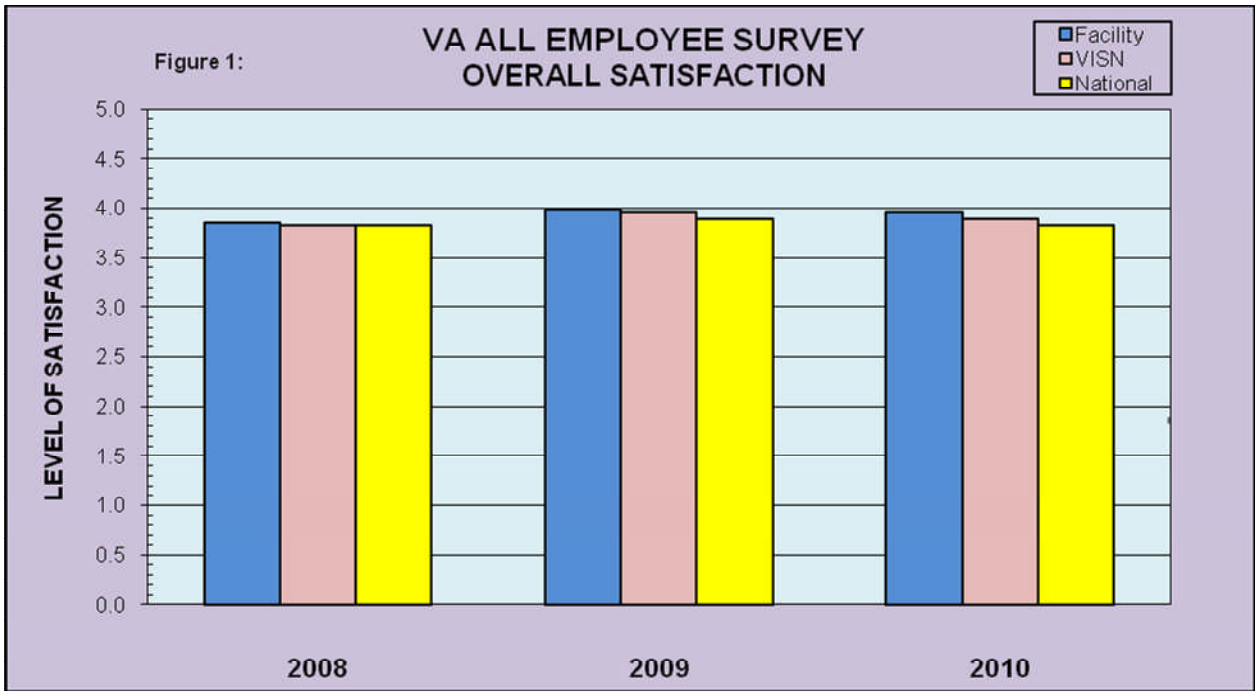
# VHA Satisfaction Surveys

VHA has identified patient and employee satisfaction scores as significant indicators of facility performance. Patients are surveyed monthly. Table 1 below shows facility, VISN, and VHA overall inpatient and outpatient satisfaction scores and targets for quarters 1–3 of FY 2010.

**Table 1**

| | FY 2010 (inpatient target = 64, outpatient target = 56) | | | | | |
|---|---|---|---|---|---|---|
| | Inpatient Score Quarter 1 | Inpatient Score Quarter 2 | Inpatient Score Quarter 3 | Outpatient Score Quarter 1 | Outpatient Score Quarter 2 | Outpatient Score Quarter 3 |
| Facility | 74.4 | 75.6 | 67.5 | 64.9 | 59.4 | 62.6 |
| VISN | 69.3 | 69.6 | 64.1 | 61.0 | 61.1 | 62.7 |
| VHA | 63.3 | 63.9 | 64.5 | 54.7 | 55.2 | 54.8 |

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.



## Hospital Outcome of Care Measures

Hospital Outcome of Care Measures show what happened after patients with certain conditions[14] received hospital care. The mortality (or death) rates focus on whether patients died within 30 days of their hospitalization. The rates of readmission focus on whether patients were hospitalized again within 30 days. Mortality rates and rates of readmission show whether a hospital is doing its best to prevent complications, teach patients at discharge, and ensure patients make a smooth transition to their home or another setting. The hospital mortality rates and rates of readmission are based on people who are 65 and older. These comparisons are "adjusted" to take into account their age and how sick patients were before they were admitted to the VA facility. Table 2 below shows the facility's Hospital Outcome of Care Measures for FYs 2006–2009.

**Table 2**

| | Mortality | | | Readmission | | |
|---|---|---|---|---|---|---|
| | Heart Attack | CHF | Pneumonia | Heart Attack | CHF | Pneumonia |
| Facility | 12.26 | 7.32 | 12.86 | 19.39 | 22.46 | 15.36 |
| VHA | 13.31 | 9.73 | 15.08 | 20.57 | 21.71 | 15.85 |

[14] CHF is a weakening of the heart's pumping power. With heart failure, your body does not get enough oxygen and nutrients to meet its needs. A heart attack (also called acute myocardial infarction) happens when blood flow to a section of the heart muscle becomes blocked and the blood supply is slowed or stopped. If the blood flow is not restored in a timely manner, the heart muscle becomes damaged from lack of oxygen. Pneumonia is a serious lung infection that fills your lungs with mucus and causes difficulty breathing, fever, cough, and fatigue.

# VISN Director Comments

**Department of Veterans Affairs** **Memorandum**

**Date:** December 7, 2010

**From:** Director, VA New England Healthcare System (10N1)

**Subj:** **CAP Review of the VA Boston Healthcare System, Boston, MA**

**To:** Director, Boston Regional Office of Healthcare Inspections (54BN)

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

I concur with the findings of the Combined Assessment Program (CAP) report submitted to the Office of the Inspector General.

*(original signed by:)*
CHRISTINE CROTEAU
*For*
MICHAEL MAYO-SMITH, MD, MPH

# Facility Director Comments

**Department of Veterans Affairs** **Memorandum**

**Date:** December 7, 2010

**From:** Director, VA Boston Healthcare System (523A4/00)

**Subj:** **CAP Review of the VA Boston Healthcare System, Boston, MA**

**To:** Director, VA New England Health Care System (10N1)

I concur with the findings of the Combined Assessment Program (CAP) report submitted to the Office of the Inspector General.

*(original signed by:)*
Michael Lawson

# 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 facility managers conduct an assessment to identify issues with crash carts and emergency kits throughout the facility and take corrective actions as necessary.

Concur

Target date for completion: Completed

1. The laryngoscopes and intubation supplies were removed from the Brockton Code Carts by COB 10/21/10 after an assessment that determined the equipment was no longer needed to maintain appropriate emergency response.

2. The "Brockton Code Cart Stock List" was amended to delete these items and a prompt added to affix an expiration sticker to the carts.

3. In servicing/alerting of affected Brockton staff to the change in code cart contents/ process has begun and is ongoing at this time.

4. The code cart contents at all three campuses were also checked for expired medical supply items and large fluorescent green sticker were affixed stating "Medical Supplies expire on…." This date will be the date of the earliest expiring item stocked on that cart. The technician stocking the cart will then initial the sticker and the cart will be sealed. A new code cart log was developed to reflect the inclusion of the additional item to be checked for expiration.

5. The SOP 5007 on Cleaning and Restocking of code carts at all three divisions has been updated to reflect these changes in process/procedure.

6. Disposable LED laryngoscope blades (#3 & 4MAC, &#4 Miller) and handles were ordered (PO # 523-r10818/ blades & 523-r10882/ handles) and replaced the re-usable laryngoscopes on the code carts on the West Roxbury and Jamaica Plain Divisions.

7. Medical Center Memorandums governing CPR procedures and acute coronary syndrome were modified and re-issued.

8. An HFMEA is being conducted on the process for response to medical emergencies. The HFMEA has a target completion date of January 31, 2011.

**Recommendation 2.** We recommended that all QM committees consistently document and track the implementation and closure of action items and include a method to track issues to completion.

Concur

Target date for completion: December 31, 2010

VA Boston Healthcare System had developed standardized tools for committees to set agendas, issue minutes and compile annual summaries that were designed to conform to the national expectation for committee work. We were in the early stages of implementation at the time of survey. September and October minutes for the Governing Board, Operative Invasive and Other Procedure Committee, Peer Review Committee, and CPR Committee were revised and reformatted to the newly introduced structure and will continue with the new structure and format. All other committees will be fully integrated into the new structure by December 31, 2010.

**Recommendation 3.** We recommended that PRC minutes contain detailed discussions of peer reviews and documentation of completed corrective actions taken on Level 3 peer reviews.

Concur

Target date for completion: October 31, 2010 – Completed

The minutes of the Peer Review Committee were modified for the months of September and October to include the details of the discussion and actions taken for Level 3 reviews. All future minutes will include details of discussions and actions taken.

**Recommendation 4.** We recommended that clinical managers fully develop professional practice evaluations for all physicians and that PSB meeting minutes reflect discussions regarding performance data prior to granting requested privileges or reprivileging.

Concur

Target date for completion: April 30, 2011

VA BHS will follow the OPPE/FPPE suggested indicators issued by the Office of Quality and Performance to ensure that the six competencies are adequately addressed. Documentation will include outcome measures along with chart reviews. All service level templates will be forwarded to the Deputy Chief of Staff for review no later than January 31, 2011 with full implementation of the template no later than April 30, 2011.

PSB minutes have adopted a new format that reflects detailed discussion of the credentialing and privileging candidates' performance data. The new format was implemented with the November, 2010 meeting.

**Recommendation 5.** We recommended that facility managers implement procedures to ensure that staff provide patients with written advance directive notification and correctly record advance directive status at each inpatient admission.

Concur

Target date for completion: April 30, 2011

The VA BHS Nursing Initial Assessment template contains several cues to remind nurses to ask the appropriate questions in regards to advance directives. Nursing staff will be re-educated in the proper use of the assessment template by January 31, 2011. Printed educational materials about advance directives will be made available to the nursing units to provide to those patients that do not go through the Admissions staff.

# OIG Contact and Staff Acknowledgments

| | |
|---|---|
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| **Report Preparation** | Produced under the direction of Claire McDonald<br>Director, Boston Regional Office of Healthcare Inspections |

# Report Distribution

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