Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 11-01104-252

Combined Assessment Program Review of the Battle Creek VA Medical Center Battle Creek, Michigan

August 15, 2011

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.

Glossary

C&P	credentialing and privileging
CAP	Combined Assessment Program
CLC	community living center
COC	coordination of care
CPRS	Computerized Patient Record System
CWAD	Crises, Warnings, Allergies and/or Adverse Reactions, and Directives
ECMS	Executive Committee of the Medical Staff
EOC	environment of care
facility	Battle Creek VA Medical Center
FY	fiscal year
JC	Joint Commission
MDRO	multidrug-resistant organisms
MEC	Medical Executive Committee
MRC	Medical Records Committee
OIG	Office of Inspector General
OPPE	Ongoing Professional Practice Evaluation
PR	peer review
QB	Quality Board
QM	quality management
SHEP	Survey of Healthcare Experiences of Patients
UM	utilization management
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network
VSB	Veterans Satisfaction Board

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Executive Summary: Combined Assessment Program Review of the Battle Creek VA Medical Center, Battle Creek, MI

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 March 28, 2011.

Review Results: The review covered six activities. The facility's reported accomplishment was the receipt of the 2010 Award for Innovation in VA Community Living Centers.

Recommendations: We made recommendations in the following six activities:

Physician Credentialing and Privileging: Review Ongoing Professional Practice Evaluation data on an ongoing basis, and ensure service-specific competency criteria is approved by the Medical Executive Committee. Review privileges to determine whether those granted are consistent with the facility's clinical practices.

Management of Test Results: Consistently document the time critical results were communicated to ordering providers and patient notification and treatment actions in response to critical results. Communicate normal test results to patients within the specified timeframe. Monitor the process of communicating test results.

Quality Management: Discuss peer review findings at the Medical Executive Committee quarterly. Discuss Utilization Management Committee reports at the Quality Board quarterly. Monitor unauthenticated documentation, and address identified medical record review problems.

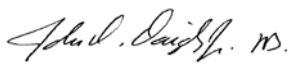
Management of Multidrug-Resistant Organisms: Provide infection prevention strategies education to patients and their families, and document it. Conduct and document required risk assessments. Ensure employees receive initial and annual education, and document it.

Coordination of Care: Document patient advance care planning using approved progress note titles. Ensure discharge instructions are consistent with current orders and include all required elements.

Environment of Care: Complete a risk assessment, and ensure all fire extinguishers are clearly marked, readily accessible, and immediately available. Ensure radiology department staff complete annual safety training, and document it. Place inspection dates on all lead shieds and aprons.

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.



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 six activities:

- COC
- EOC
- Management of MDRO
- Management of Test Results
- Physician C&P
- QM

The review covered facility operations for FY 2010 and FY 2011 through March 28, 2011, and was done in accordance with OIG standard operating procedures for CAP reviews. We also followed up on selected recommendations from our prior CAP review of the facility (*Combined Assessment Program Review of the Battle Creek VA Medical Center, Battle Creek, Michigan,* Report No. 08-00399-131,

May 29, 2008). The facility had corrected all findings. (See Appendix B for further details.)

During this review, we also presented crime awareness briefings for 68 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 Accomplishment

2010 VA Innovation Award

In 2010, the facility received the Award for Innovation in VA Community Living Centers. This award recognized Battle Creek's accomplishment in transforming the CLC culture.

Results

Review Activities With Recommendations

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 13 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 areas that needed improvement.

OPPE. VHA requires that data consistent with service-specific competency criteria be collected, maintained in each physician's profile, and reviewed on an ongoing basis.[1] VHA also requires the criteria to be approved by the MEC. For the 10 reprivileged physicians whose profiles we reviewed, OPPE data were not reviewed on an ongoing basis and did not include service-specific competency criteria approved by the MEC.

Facility-Specific Privileges. VHA requires that privileges be facility specific. Only privileges for procedures actually provided by the facility may be granted to a practitioner.[2] Endotracheal intubation is a procedure that is beyond the

[1] VHA Handbook 1100.19, Credentialing and Privileging, November 14, 2008.
[2] VHA Handbook 1100.19.

scope of service designated for this facility. However, we found that 17 (30 percent) of the 56 providers at the facility were privileged to perform this procedure.

Recommendations

1. We recommended that OPPE data be reviewed on an ongoing basis and that service-specific competency criteria be approved by the MEC.

2. We recommended that all privileges be reviewed to determine whether the privileges granted are consistent with the clinical practices of the facility.

Management of Test Results

The purpose of this review was to follow up on a previous review that identified improvement opportunities related to documentation of notification of abnormal test results and follow-up actions taken.[3]

We reviewed the facility's policies and procedures, and we reviewed medical records. We identified the following areas that needed improvement.

Documentation of Ordering Provider Notification. VHA requires that diagnostic laboratory and radiology clinicians document in the medical record the time and means of critical test result communication and the name of the ordering provider contacted.[4] We reviewed the medical records of 20 patients who had critical results and found that diagnostic clinicians did not document the time the ordering provider was notified in 9 of the 20 records.

Documentation of Patient Notification and Treatment Actions. VHA requires ordering providers to document in the medical record patient notification and treatment actions in response to critical test results.[5] We reviewed the medical records of 20 patients who had critical results and did not find documented evidence of patient notification and follow-up actions in 3 of the 20 records.

Communication of Normal Results. VHA requires facilities to communicate normal results to patients no later than 14 calendar days from the date that the results were available to the ordering provider.[6] We reviewed the medical

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

records of 20 patients who had normal results and found that 9 of 20 records did not contain documented evidence that the facility had communicated the results to the patients.

Monitoring Results Communication. VHA requires facilities to monitor the effectiveness of communication of results to providers and patients.[7] We determined that the facility had an established process for monitoring communication of laboratory and radiology results to ordering providers. However, the monitoring was based on a 60-minute timeframe when the time required by local policy is 30 minutes. In addition, we did not find evidence that communication of test results to patients was periodically monitored.

Recommendations

3. We recommended that diagnostic clinicians consistently document the time critical results were communicated to ordering providers and that ordering providers consistently document patient notification and treatment actions in response to critical results.

4. We recommended that normal test results be consistently communicated to patients within the specified timeframe.

5. We recommended that the process of communicating test results to providers and patients be periodically monitored for effectiveness to ensure compliance with VHA and local policies.

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.

PR. VHA requires the MEC, or its equivalent, to review PR results on a quarterly basis.[8] We found that the MEC discussed PR findings in only 2 of the past 4 quarters.

[7] VHA Directive 2009-019.
[8] VHA Directive 2010-025, *Peer Review for Quality Management*, June 3, 2010.

UM. Local policy requires the QB to review UM Committee reports quarterly. We found that the QB reviewed reports in only 2 of the past 4 quarters.

Medical Records Quality Review. VHA requires the MRC to provide oversight and coordination of medical record quality review activities.[9] The MRC did not monitor unauthenticated documentation or ensure that action plans resulted in remediation of identified deficiencies.

Recommendations

6. We recommended that PR findings be discussed at the MEC quarterly.

7. We recommended that UM Committee reports be discussed at the QB quarterly.

8. We recommended that unauthenticated documentation be monitored and that processes for addressing identified medical record review problems be strengthened.

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 inspected a medical unit and the CLC, and we interviewed four employees. We did not identify deficits in either the inspections or staff interviews. However, we identified the following areas that needed improvement.

Patient/Family Education. The JC requires that patients infected or colonized[10] with MDRO and their families receive education on infection prevention strategies, such as hand washing and the proper use of personal protective equipment. We reviewed 12 medical records and found no documented evidence of MDRO education.

MDRO Risk Assessment. The JC requires that facilities conduct a risk assessment to determine the need for staff education. There was no evidence that the facility had conducted an MDRO risk assessment.

Employee Training. Facility policy requires staff to have MDRO training during orientation and annually thereafter. We reviewed 20 employee training records and found that

[9] VHA Handbook 1907.01, *Health Information Management and Health Records*, August 25, 2006.
[10] Colonization is the presence of bacteria in the body without causing clinical infection.

3 records had no documentation of initial or annual MDRO education.

Recommendations

9. We recommended that infection prevention strategies education be provided to patients infected or colonized with MDRO and their families and be documented.

10. We recommended that the required MDRO risk assessments be conducted and documented.

11. We recommended that employees receive initial and annual MDRO education and that the training be consistently documented.

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 Care Planning Progress Note Titles. VHA requires that staff use specific progress note titles when documenting advance care planning discussions with patients and link these notes to the CWAD posting in the electronic medical record.[11] We reviewed 10 patient medical records and determined that in two of the records, the facility did not use the required progress note titles. In addition, two advance care planning documentation notes were not linked to the CWAD posting.

Discharge Instructions. VHA requires that upon discharge from the facility, providers include information regarding medications, diet, activity level, and follow-up appointments in instructions to patients.[12] In addition, the JC requires that clinicians provide patients with written discharge instructions.

We reviewed the medical records of 10 discharged patients and found that two records did not address all required elements. Additionally, we identified three patients whose diet orders were not consistent with their dietary discharge instructions.

[11] VHA Handbook 1004.02, *Advance Care Planning and Management of Advance Directives*, July 2, 2009.
[12] VHA Handbook 1907.01.

Recommendations

12. We recommended that staff document patient advance care planning using approved progress note titles and link the notes to the CWAD posting.

13. We recommended that processes be strengthened to ensure that discharge instructions are consistent with current orders and include all required elements.

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 CLC, a medical unit, the urgent care area, a behavioral health unit, outpatient clinical areas, and radiology. The facility maintained a generally clean and safe environment. However, we identified the following areas that needed improvement.

Fire and Life Safety. The National Fire Protection Association requires portable fire extinguishers to be conspicuously marked, readily accessible, and immediately available. In all areas inspected, we found fire extinguishers stored in locked cabinets without conspicuous markings and with no means of emergency access.

Radiation Safety. Local policy requires annual radiation safety training for radiology department employees. We reviewed training records for five radiology technologists; none of the records had documentation of radiation safety training.

The Occupational Safety and Health Administration requires that lead shields and aprons be periodically inspected and that the inspection date be placed on those items. While the facility is conducting periodic inspections, they do not place the inspection dates on the shields and aprons.

Recommendations

14. We recommended that a risk assessment be completed and that all fire extinguishers be conspicuously marked, readily accessible, and immediately available.

15. We recommended that radiology department staff complete annual radiation safety training and that the training be documented.

16. We recommended that inspection dates be placed on all lead shields and aprons.

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 15–21, for the full text of the Directors' comments.) We will follow up on the planned actions until they are completed.

Facility Profile[13]		
Type of Organization	Mental health, primary care, physical medicine and rehabilitation, extended care, and long-term care	
Complexity Level	3	
VISN	11	
Community Based Outpatient Clinics	Grand Rapids, MI Muskegon, MI Benton Harbor, MI Lansing, MI	
Veteran Population in Catchment Area	187,431	
Type and Number of Total Operating Beds: • **Hospital, including Psychosocial Residential Rehabilitation Treatment Program**	239	
• **CLC/Nursing Home Care Unit**	109	
• **Other**	N/A	
Medical School Affiliation(s)	Michigan State University	
• **Number of Residents**	8	
	Current FY (through March 2011)	**Prior FY (2010)**
Resources (in millions):		
• **Total Medical Care Budget**	$233.7	$221.6
• **Medical Care Expenditures**	$116.1	$218.8
Total Medical Care Full-Time Employee Equivalents	1,267.3	1,268.4
Workload:		
• **Number of Station Level Unique Patients**	20,693	20,425
• **Inpatient Days of Care:**		
o **Acute Care**	2,310	4,840
o **CLC/Nursing Home Care Unit**	15,393	31,489
Hospital Discharges	500	3,088
Total Average Daily Census (including all bed types)	226.3	233
Cumulative Occupancy Rate (in percent)	70.5	68
Outpatient Visits	63,457 (through January 2011)	374,438

[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**
QM			
1. Ensure VHA requirements for PRs are met.	PRs are being completed within the required timeframe. PR minutes are being reported to the QB for oversight, and the QB is reviewing trends in changes from one rating level to another.	Y	N
2. Require that patient complaint data be compared to SHEP results and that corrective action be initiated and monitored.	Patient complaint data is tracked, aggregated, and compared to SHEP survey results. The VSB discusses the data, the recently hired Planetree coordinator takes action on the identified opportunities, and the activities are reported to the ECMS.	Y	N
3. Ensure importing and copying of text in the electronic medical records is monitored.	The concerns regarding importing and copying of text in the electronic medical record has been addressed. In 2008, a specific monitor for the "copy and paste" functionality was included as part of ongoing point of care medical record reviews. Additionally, inappropriate use of copy and paste is monitored on physician OPPEs.	Y	N

Recommendations	Current Status of Corrective Actions Taken	In Compliance Y/N	Repeat Recommendation? Y/N
4. Ensure adverse event disclosures are monitored in accordance with VHA policy.	Local policy, which is consistent with VHA policy, outlines the requirements for disclosure and documentation related to adverse events. There has not been an institutional adverse event since 2008, but all adverse events are tracked.	Y	N
5. Ensure the Chief of Staff conducts an independent review of two patients identified as having experienced adverse events to ensure that VHA policy is followed.	The Chief of Staff independently reviewed the two patients identified, and disclosures were completed May 30, 2008.	Y	N
6. Require the facility to strengthen communication and collaboration among UM, medical care cost recovery, and fee basis staff.	As evidenced by local policy and the minutes of the UM Committee, communication and collaboration among UM, medical care cost recovery, and fee basis staff have improved.	Y	N
EOC			
7. Ensure infection control vulnerabilities are corrected.	Emergency call system cords are properly placed and clean; medication refrigerators have central temperature control, and no damaged or dirty seals are evident; patient care equipment with compromised surfaces has been removed, and the remaining equipment is clean; and the damaged ceiling tiles have been replaced and are maintained.	Y	N

Recommendations	Current Status of Corrective Actions Taken	In Compliance Y/N	Repeat Recommendation? Y/N
8. Ensure safety vulnerabilities are corrected.	Ceiling tiles are properly clipped; no dirty linen receptacles are in unprotected areas; inappropriate shower control fixtures were replaced; splintered doors have been replaced and are maintained; and oxygen tanks are properly secured and stored.	Y	N
9. Require patient privacy vulnerabilities to be corrected.	There are no clipboards or charts visible, and there have been no incidences of visible patient information. Care-trackers have been installed.	Y	N
CPRS Business Rules			
10. Ensure CPRS business rules comply with VHA policy and Office of Information guidance.	Software informational patch USR*1*26 is in place, and we are currently up to sequence 32 on the package.	Y	N
SHEP			
11. Require an action plan to be implemented to improve patient satisfaction that includes measurable goals and assigns responsibility for completion of tasks.	An action plan has been implemented to improve patient satisfaction. In addition, a Planetree coordinator was hired to oversee the identified opportunities and progress made. This information is discussed and shared with the VSB and the ECMS.	Y	N

VHA Satisfaction Surveys

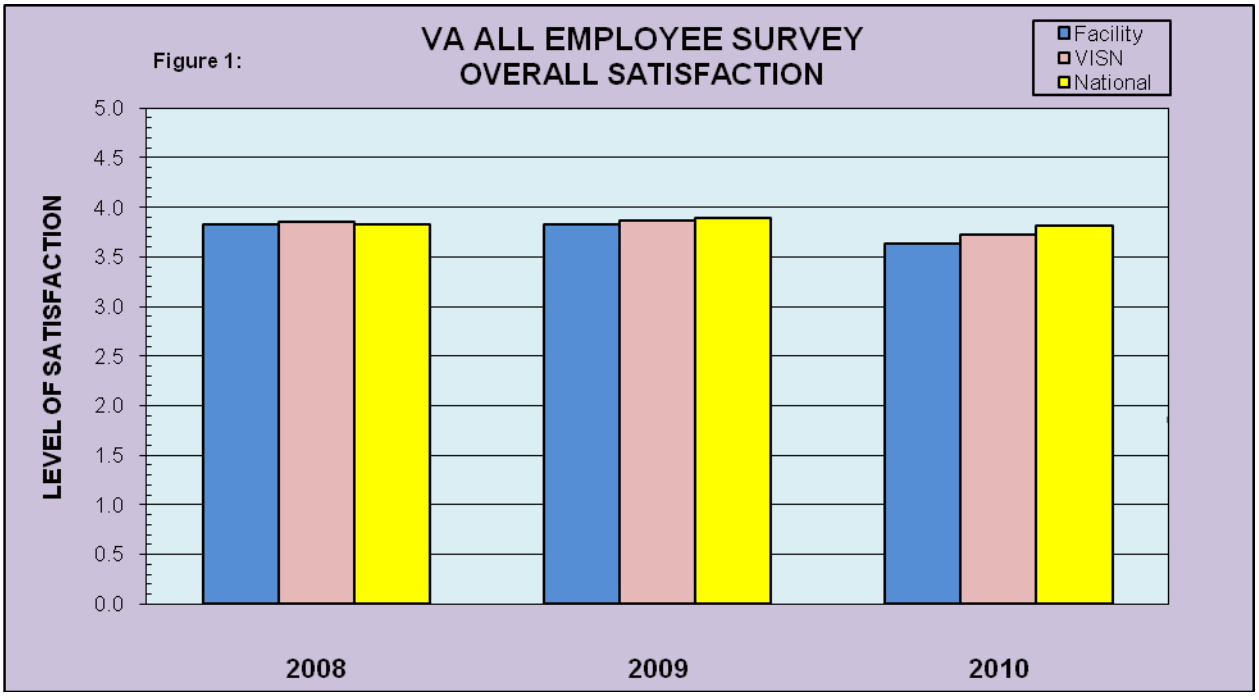
VHA has identified patient and employee satisfaction scores as significant indicators of facility performance. Patients are surveyed monthly. Table 1 below shows facility, VISN, and VHA overall inpatient and outpatient satisfaction scores and targets for FY 2010.

Table 1

	FY 2010 (inpatient target = 64, outpatient target = 56)							
	Inpatient Score Quarter 1	Inpatient Score Quarter 2	Inpatient Score Quarter 3	Inpatient Score Quarter 4	Outpatient Score Quarter 1	Outpatient Score Quarter 2	Outpatient Score Quarter 3	Outpatient Score Quarter 4
Facility	33.8	39.6	51.9	48.8	57.6	54.2	54.0	55.0
VISN	67.4	66.1	65.6	70.1	53.4	54.5	56.3	55.7
VHA	63.3	63.9	64.5	63.8	54.7	55.2	54.8	54.4

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.

Figure 1:



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	Congestive Heart Failure	Pneumonia	Heart Attack	Congestive Heart Failure	Pneumonia
Facility	*	11.34	14.44	*	19.81	15.41
VHA	13.31	9.73	15.08	20.57	21.71	15.85

* Not enough cases.

[14] Congestive heart failure 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: July 19, 2011

From: Director, Veterans in Partnership Network (10N11)

Subject: **CAP Review of the Battle Creek VA Medical Center, Battle Creek, MI**

To: Director, Seattle Office of Healthcare Inspections (54SE)

Director, Management Review Service (VHA 10A4A4 Management Review)

1. Attached is Battle Creek's response to the draft report of the Combined Assessment Program (CAP) review of the Battle Creek VA Medical Center.

2. If you have any questions, please contact Ms. Kelley Sermak, Acting Quality Management Officer at 734-222-4302.

Michael S. Finegan, Director, VISN 11 (10N11)

Facility Director Comments

Department of Veterans Affairs **Memorandum**

Date: July 19, 2011

From: Director, Battle Creek VA Medical Center (515/00)

Subject: **CAP Review of the Battle Creek VA Medical Center, Battle Creek, MI**

To: Director, Veterans in Partnership Network (10N11)

1. I have reviewed the draft report of the Inspector General's Combined Assessment Program (CAP) of the Battle Creek VA Medical Center. We concur with all the findings and recommendations.

2. I appreciate the opportunity for this review as a continuing process to improve the care to our Veterans. Thank you.

Suzanne M. Klinker

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 OPPE data be reviewed on an ongoing basis and that service-specific competency criteria be approved by the MEC.

Concur

Target date for completion: Completed April 11, 2011

Service specific competency criteria are included on Professional Practice Evaluations (PPE), both Focused and Ongoing, these are approved and monitored by the Service and the Executive Committee of the Medical Staff (ECMS). The Ongoing Professional Practice Evaluation (OPPE) is being reviewed in a regular basis by the Service and ECMS. The credentialing office has met with each Service and coordinated the review dates for each provider OPPE. Also, the credentialing office sends Service Chiefs notifications and reminders regarding OPPEs up for review.

Recommendation 2. We recommended that all privileges be reviewed to determine whether the privileges granted are consistent with the clinical practices of the facility.

Concur

Target date for completion: Completed April 12, 2011

A review of credentialing and privileging records was completed. As of April 12, 2011, Endotracheal Intubation privilege was administratively removed from all seventeen providers with this privilege.

Recommendation 3. We recommended that diagnostic clinicians consistently document the time critical results were communicated to ordering providers and that ordering providers consistently document patient notification and treatment actions in response to critical results.

Concur

Target date for completion: Completed April 29, 2011

Diagnostic clinicians and providers have been re-educated on documentation requirements regarding communication of critical test results and treatment actions. Immediately following recognition of critical results, the ordering provider is informed by direct communication utilizing the write down/read back method, the content and time of

this communication is recorded in the medical record. The process is being monitored daily by the Radiology Supervisor and reported to the Chief of Staff.

Recommendation 4. We recommended that normal test results be consistently communicated to patients within the specified timeframe.

Concur

Target date for completion: Completed April 29, 2011

All clinicians who order diagnostic testing have been provided training on the requirements to notify patients of normal test results within 14-days and methods available to communicate the information. This is completed during initial orientation and is discussed regularly at staff meetings and team meetings. Clinical Services have been conducting reviews on randomly selected samples of medical records for each provider.

Recommendation 5. We recommended that the process of communicating test results to providers and patients be periodically monitored for effectiveness to ensure compliance with VHA and local policies.

Concur

Target date for completion: Completed April 29, 2011

Results of medical records reviews conducted by clinical Services will be presented at the Clinical Executive Board (CEB) for review and to recommend corrective actions as appropriate; CEB will report results to Executive Leadership Board. This process has been initiated, Services will present to CEB in a regular basis. Clinical Services have also incorporated timely test results notification in the Focused and Ongoing Professional Practice Evaluations (FPPE/OPPE).

Recommendation 6. We recommended that PR findings be discussed at the MEC quarterly.

Concur

Target date for completion: Completed April 11, 2011

Peer Review level assignment data, action items log and other pertinent information will be shared with the Executive Committee of the Medical Staff (ECMS) at least quarterly; the process has been initiated and is a regular agenda item.

Recommendation 7. We recommended that UM Committee reports be discussed at the QB quarterly.

Concur

Target date for completion: Completed April 18, 2011

Beginning fiscal year 2011, the Quality Board began review of Utilization Management Committee reports and minutes as a standing agenda item, discussed on a quarterly basis, and are recorded in the Quality Board minutes. In addition, Utilization Management personnel submit daily updates to Leadership during the morning reports.

Recommendation 8. We recommended that unauthenticated documentation be monitored and that processes for addressing identified medical record review problems be strengthened.

Concur

Target date for completion: July 30, 2011

A report of unauthenticated medical records documentation will be run twice a week and will be addressed with Service Chiefs for completion. Starting at the July 2011 meeting, the Medical Records Committee (MRC) will review the reports, corrective actions taken and outcomes; this review will become a standing agenda item. Also, at this meeting, the MRC will review current tool used by the committee for medical records review. Service Chiefs will be asked to present corrective actions taken to address the findings of the medical records review process at the MRC meeting following the reporting of findings to the Service.

Recommendation 9. We recommended that infection prevention strategies education be provided to patients infected or colonized with MDRO and their families and be documented.

Concur

Target date for completion: Completed May 27, 2011

A template progress note (resident/veteran/family education note) was developed and is now implemented. Educational materials have been provided to medical unit, inpatient mental health, and community living center.

Recommendation 10. We recommended that the required MDRO risk assessments be conducted and documented.

Concur

Target date for completion: Completed April 6, 2011

The risk assessment has been conducted and documented and will be repeated yearly.

Recommendation 11. We recommended that employees receive initial and annual MDRO education and that the training be consistently documented.

Concur

Target date for completion: Completed May 13, 2011

MDRO education is provided to employees upon hire at New Employee Orientation and annually thereafter. Current employees have the MDRO education module added to their annual curriculum and is documented in the Talent Management System.

Recommendation 12. We recommended that staff document patient advance care planning using approved progress note titles and link the notes to the CWAD posting.

Concur

Target date for completion: July 29, 2011

Approved progress note titles implemented and linked to CWAD. Staff training on this process will be completed by July 29, 2011.

Recommendation 13. We recommended that processes be strengthened to ensure that discharge instructions are consistent with current orders and include all required elements.

Concur

Target date for completion: Completed June 24, 2011

The Inpatient Discharge Instructions template has been modified to make all elements required; clinicians will not be able to complete or sign the note until information is entered on all required fields. Since discharge orders will transfer automatically to the Inpatient Discharge Instructions template, providers are mandated to review current orders at time of discharge to ensure consistency.

Recommendation 14. We recommended that a risk assessment be completed and that all fire extinguishers be conspicuously marked, readily accessible, and immediately available.

Concur

Target date for completion: September 1, 2011

A risk assessment addressing the locking of fire extinguishers in cabinets where they are subject to physical damage, along with their marking will be completed by the medical center's Fire Service, and coordinated through the medical center's Safety Committee for action as appropriate.

Recommendation 15. We recommended that radiology department staff complete annual radiation safety training and that the training be documented.

Concur

Target date for completion: July 8, 2011

An annual radiation safety training course and test were added to the Talent Management System (TMS) and this training was assigned to all radiology department employees on May 9, 2011. This training will be recorded and tracked by the Chief, Ancillary Services to ensure that all radiology department employees have completed this training by July 8, 2011 and annually thereafter.

Recommendation 16. We recommended that inspection dates be placed on all lead shields and aprons.

Concur

Target date for completion: Completed March 31, 2011

On March 31, 2011 inspection dates were placed on all lead shields and aprons. These items are periodically reviewed and inspected and the respective date placed on the item.

OIG Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the Office of Inspector General at (202) 461-4720
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U.S. Senate: Carl Levin, Debbie Stabenow
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