Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 11-01610-278

Combined Assessment Program Review of the Minneapolis VA Health Care System Minneapolis, Minnesota

September 13, 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.

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Glossary

AD	advance directive
C&P	credentialing and privileging
CAP	Combined Assessment Program
CLC	community living center
COC	coordination of care
CPR	cardiopulmonary resuscitation
ED	emergency department
EN	enteral nutrition
EOC	environment of care
facility	Minneapolis VA Health Care System
FY	fiscal year
OIG	Office of Inspector General
OSHA	Occupational Safety and Health Administration
PI	performance improvement
PR	peer review
QM	quality management
RN	registered nurse
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

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Executive Summary: Combined Assessment Program Review of the Minneapolis VA Health Care System, Minneapolis, MN

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 June 13, 2011.

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

- Enteral Nutrition Safety
- Management of Workplace Violence
- Medication Management
- Registered Nurse Competencies

The facility's reported accomplishments were having the lowest 30-day mortality rates for acute myocardial infarction and heart failure among Minnesota hospitals and a facility physician who received a Veterans Health Administration ethics award.

Recommendations: We made recommendations in the following four activities:

Environment of Care: Ensure that emergency medications in tackle boxes are monitored for expiration dates and that expired medications are removed. Maintain vaginal speculums in sterile packaging until used. Complete annual bloodborne pathogens training and N95 respirator fit testing, and monitor compliance.

Quality Management: Complete all peer reviews within the 120-day timeframe or have an extension that is approved in writing by the facility Director prior to the deadline. Ensure moderate sedation documentation includes a review of current medications and evidence the patient was discharged in the company of a responsible, designated adult, and monitor compliance. Review each resuscitation event and analyze all required data elements.

Coordination of Care: Update the facility advance directive policy to comply with Veterans Health Administration policy. Provide all components of written advance directive notification to patients, and document advance directive notification and screening in the medical record.

Physician Credentialing and Privileging: Ensure physician clinical privileges are service/setting specific.

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 eight activities:

- COC
- EN Safety
- EOC
- Management of Workplace Violence
- Medication Management
- Physician C&P
- QM
- RN Competencies

The review covered facility operations for FY 2010 and FY 2011 through June 13, 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 Minneapolis VA Medical*

Center, Minneapolis, Minnesota, Report No. 08-00402-16, October 29, 2008). (See Appendix B for further details.) We identified one repeat finding in QM.

During this review, we also presented crime awareness briefings for 202 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

Lowest Mortality Rates Among Minnesota Hospitals for Two Diagnoses

From July 1, 2007, through June 30, 2010, the Centers for Medicare and Medicaid Services' Hospital Inpatient Quality Reporting program compared mortality and readmission rates for 132 hospitals in Minnesota. The facility demonstrated the lowest rates, which were better than the national rates, for acute myocardial infarction and heart failure 30-day mortality. Additionally, the facility ranked 10 out of 125 Minnesota hospitals for acute myocardial infarction 30-day readmission and 23 out of 132 hospitals for heart failure 30-day readmission.

Physician Received VHA Ethics Award

A facility physician, the Co-Director of the CLC, received the 2010 William A. Nelson Award for Excellence in Health Care Ethics. Since 2005, this annual award has recognized an individual who has demonstrated a long-term commitment to promoting ethical health care practice in VHA through excellence, dedication, and accomplishments in the field of health care ethics. The physician heads the facility's Ethics Consultative Services and co-chairs the Compliance and Integrated Ethics Council.

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 one medical, one surgical, and one CLC unit; the medical intensive care, spinal cord injury, polytrauma, locked inpatient mental health, and extended care

rehabilitation units; and the ED. We also inspected one primary care clinic and the women's comprehensive health clinic. The facility maintained a generally clean and safe environment. However, we identified the following conditions that needed improvement.

Patient Safety. The Joint Commission requires that expired medications be removed and separated from medications available for administration. In the spinal cord injury unit, we found a tackle box with 14 expired emergency medications.

Infection Control. Local policy requires that sterilized instruments be packaged. We inspected the women's comprehensive health clinic and found two basins of unwrapped metal vaginal speculums on the floor in the sterile supply room and a tray of unwrapped metal vaginal speculums on a shelf in a wall cabinet.

OSHA requires that employees with occupational exposure risk receive annual training on the OSHA Bloodborne Pathogens Rule. We reviewed 13 employee training records and found that 3 employees did not have this training documented.

If facilities use N95 respirators, OSHA requires that designated employees are fit tested annually. We reviewed 25 employee training records and determined that 19 designated employees did not have the required annual fit testing.

Recommendations

1. We recommended that processes be strengthened to ensure that emergency medications in tackle boxes are monitored for expiration dates and that expired medications are removed.

2. We recommended that vaginal speculums be maintained in sterile packaging until used.

3. We recommended that annual OSHA bloodborne pathogens training and N95 respirator fit testing be completed and that compliance be monitored.

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. Once the need for a PR is determined, VHA requires that the final review be completed within 120 days or that an extension be requested from and approved in writing by the facility's Director.[1] Four of the PRs initiated from January 2010 through December 2010 exceeded the 120-day timeframe. No extensions had been requested for two of the PRs, and extensions for the other two had been requested and approved after the 120-day deadline. This was a repeat finding from the previous CAP review.

Moderate Sedation. VHA requires that providers assess patients undergoing moderate sedation.[2] These assessments must include a review of current medications. VHA also requires that outpatients who undergo moderate sedation are discharged in the company of a responsible, designated adult. We reviewed the medical records of 10 outpatients who underwent moderate sedation and found that 5 of the records did not include documentation of a review of current medications. These same five records also did not contain evidence that the patients were discharged in the company of a responsible, designated adult.

Resuscitation Outcomes. VHA requires that each facility have a policy mandating the membership and responsibilities of a CPR committee or its equivalent.[3] Facility policy requires that the CPR/Rapid Response Team Subcommittee review individual cardiopulmonary arrests occurring at the facility and aggregate data to identify and address any trends. We found that the subcommittee did not review all individual CPR event outcomes nor did it critically analyze data from resuscitation episodes to identify trends.

Recommendations

4. We recommended that all PRs be completed within the 120-day timeframe or have an extension that is approved in writing by the facility Director prior to the 120-day deadline.

5. We recommended that processes be strengthened to ensure that moderate sedation documentation includes a

[1] VHA Directive 2010-025, *Peer Review for Quality Management*, June 3, 2010.
[2] VHA Directive 2006-023, *Moderate Sedation by Non-Anesthesia Providers*, May 1, 2006.
[3] VHA Directive 2008-063, *Oversight and Monitoring of Cardiopulmonary Resuscitative Events and Facility Cardiopulmonary Resuscitation Committees*, October 17, 2008.

review of current medications and evidence the patient was discharged in the company of a responsible, designated adult and that compliance is monitored.

6. We recommended that the CPR/Rapid Response Team Subcommittee review each resuscitation event and analyze all required data elements.

COC

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

We reviewed patients' medical records for evidence of AD notification, AD screening, and documentation of advance care planning discussions. We also reviewed the facility's policy to determine whether it was consistent with VHA policy. We identified the following areas that needed improvement.

Facility Policy. VHA requires AD notification and screening at each admission to a VHA inpatient facility.[4] Facility policy was not consistent with VHA policy regarding this requirement. For example, facility policy directs staff to only screen and notify patients if they do not have a documented AD linked to the Crisis, Warnings, Allergies and/or Adverse Reactions and Directives posting.

AD Notification and Screening. VHA requires that patients receive written notification at each admission to a VHA facility regarding their right to accept or refuse medical treatment, to designate a Health Care Agent, and to document their treatment preferences in an AD.[5] As part of notification, patients must be informed that VA does not discriminate based on whether or not they have an AD. We reviewed the medical records of 20 patients and found that none of the records contained evidence of all components of written notification.

In addition, VHA requires that staff screen patients at each admission to a VHA facility to determine whether they have an AD and document the screening in the medical record.[6] Facility staff did not document this screening for 18 of 20 patients whose medical records we reviewed.

[4] VHA Handbook 1004.02, *Advance Care Planning and Management of Advance Directives*, July 2, 2009.
[5] VHA Handbook 1004.02.
[6] VHA Handbook 1004.02.

Recommendations

7. We recommended that the facility AD policy be updated to comply with VHA policy.

8. We recommended that processes be strengthened to ensure that all components of written AD notification are provided to patients and that AD notification and screening are documented in the medical record.

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 15 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.

Service/Setting-Specific Privileges. VHA requires that clinical privileges be service/setting specific for each clinical site.[7] We found that three of the physicians whose profiles we reviewed had been granted clinical privileges that were not supported by the service or setting where the physicians practiced. For example, a provider working in a community based outpatient clinic had been granted privileges to perform invasive procedures, which the setting did not support.

Recommendation

9. We recommended that processes be strengthened to ensure that physician clinical privileges are service/setting specific.

Review Activities Without Recommendations

EN Safety

The purpose of this review was to evaluate whether the facility established safe and effective EN procedures and practices in accordance with applicable requirements.

We reviewed policies and documents related to EN and patients' medical records. We also inspected areas where EN products were stored while conducting the EOC review, and we interviewed key employees. We determined that the facility generally met EN safety requirements. We made no recommendations.

[7] VHA Handbook 1100.19, *Credentialing and Privileging*, November 14, 2008.

Management of Workplace Violence

The purpose of this review was to determine whether VHA facilities issued and complied with comprehensive policy regarding violent incidents and provided required training.

We reviewed the facility's policy and training plan. Additionally, we selected three assaults that occurred at the facility within the past 2 years, discussed them with managers, and reviewed applicable documents. The facility had a comprehensive workplace violence policy and managed the assaults in accordance with policy. The training plan addressed the required prevention and management of disruptive behavior training. 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.

RN Competencies

The purpose of this review was to determine whether the facility had an adequate RN competency assessment and validation process.

We reviewed facility policies and processes, interviewed nurse managers, and reviewed initial and ongoing competency assessment and validation documents for RNs. We determined that the facility had established an effective process to ensure that RN competencies were assessed and validated and that a plan was in place to take action if deficiencies were identified. 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 14–18 for full text of the Directors' comments.) We will follow up on the planned actions until they are completed.

Facility Profile[8]		
Type of Organization	Tertiary care medical center	
Complexity Level	1a	
VISN	23	
Community Based Outpatient Clinics	Cook, MN Hibbing, MN Mankato, MN Maplewood, MN Rochester, MN St. James, MN Chippewa Falls, WI Hayward, WI Rice Lake, WI Superior, WI	
Veteran Population in Catchment Area	397,180 (Minneapolis and St. Cloud catchment areas)	
Type and Number of Total Operating Beds: • **Hospital, including Psychosocial Residential Rehabilitation Treatment Program**	199	
• **CLC/Nursing Home Care Unit**	80	
Medical School Affiliation(s)	University of Minnesota	
• **Number of Residents**	653	
	FY 2011 (through March 2011)	**Prior FY (2010)**
Resources (in millions):		
• **Total Medical Care Budget**	$324.8	$474.7
• **Medical Care Expenditures**	$268.1	$472
Total Medical Care Full-Time Employee Equivalents	3,158	3,151
Workload:		
• **Number of Station Level Unique Patients**	69,275	89,087
• **Inpatient Days of Care:**		
o **Acute Care**	24,642	48,781
o **CLC/Nursing Home Care Unit**	9,271	22,260
Hospital Discharges	4,209	8,487
Total Average Daily Census (including all bed types)	186.3	194.6
Cumulative Occupancy Rate (in percent)	65.4	69.7
Outpatient Visits	381,173	750,485

[8] 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. Collect and consider provider-specific PI data during reprivileging, in accordance with VHA policy.	Provider-specific PI data are collected for all privileged medical staff members and are reviewed on an ongoing basis and at the time of reprivileging.	Y	N
2. Complete PRs within the timeframes specified in VHA policy, and trend and analyze results to identify opportunities for improvement.	Four of the PRs initiated from January 2010 through December 2010 were not completed within 120 days. PR results are trended and analyzed to identify improvement opportunities.	N	Y (see page 4)
3. Complete root cause analyses within the timeframe specified in VHA policy.	Root cause analyses are completed within the specified timeframe.	Y	N
4. Communicate patient complaint data and the resulting PI initiatives to senior managers and the Quality Manager, in accordance with VHA policy.	The Patient Family Center Director presents quarterly reports to the QM and Patient Service Councils. The Patient Service Council provides summaries, which include patient complaint data and PI initiatives, to the Executive Leadership Board.	Y	N
Pharmacy Operations			
5. Require monthly, randomly scheduled inspections of all controlled substance areas, in accordance with VHA policy.	The Controlled Substance Coordinator developed a schedule to assist in randomizing inspections. Inspections are monitored monthly by the Controlled Substance Leadership Workgroup. All inspections have been completed through March 2011.	Y	N

Recommendations	Current Status of Corrective Actions Taken	In Compliance Y/N	Repeat Recommendation? Y/N
6. Include internal and external notification procedures in the facility controlled substance policy, in accordance with VHA policy.	Facility policy was updated to reflect appropriate adherence to VHA policy to assure compliance in notification of discrepancies, diversions, and suspected thefts.	Y	N
Medication Management			
7. Require staff to follow facility policy regarding medication disposition upon admission.	Facility policy was modified, and staff were educated on the procedure for disposition of medication upon admission.	Y	N
COC			
8. Require staff to complete intra-facility transfer assessments within the timeframes specified in facility policy.	The Office of Professional Nursing Service updated policy on January 15, 2009, and provided staff education. The policy outlines specific timeframes for initial/immediate assessments on transfers. Intra-facility transfer assessments are completed within the required timeframes.	Y	N
9. Require provider discharge summaries to be consistent with patient discharge orders.	Mental health nurses identified this as an opportunity and instituted the Discharge Medication Reconciliation template specific for Unit 1K. Current practice is to use the template and follow the appropriate medication reconciliation process to ensure consistency between discharge summaries and discharge orders.	Y	N

Recommendations	Current Status of Corrective Actions Taken	In Compliance Y/N	Repeat Recommendation? Y/N
EOC			
10. Correct identified safety and infection control deficiencies.	1. A remote refrigerator monitoring system was installed and is functioning well. 2. Medications and cleaning supplies are secured when not in use. 3. All clean linens are appropriately stored. 4. There are designated areas with appropriate signage for full and empty oxygen tanks. 5. Shatterproof mirrors were installed on the locked mental health unit.	Y	N
ED Operations			
11. Require that patients discharged from the ED receive written discharge instructions.	Staff and moonlighters in the ED have been educated on ED patient discharges. Patients are receiving appropriate discharge instructions.	Y	N
Staffing			
12. Take action to ensure managers provide the nursing staff required by the established staffing methodology.	Nurse managers review hours per patient day daily, note when staffing is above or below guidelines, and take corrective action as indicated. Nurse managers and supervisors coordinate to staff for unplanned losses. Chief nurses review reports weekly and make recommendations for change.	Y	N

VHA Satisfaction Surveys

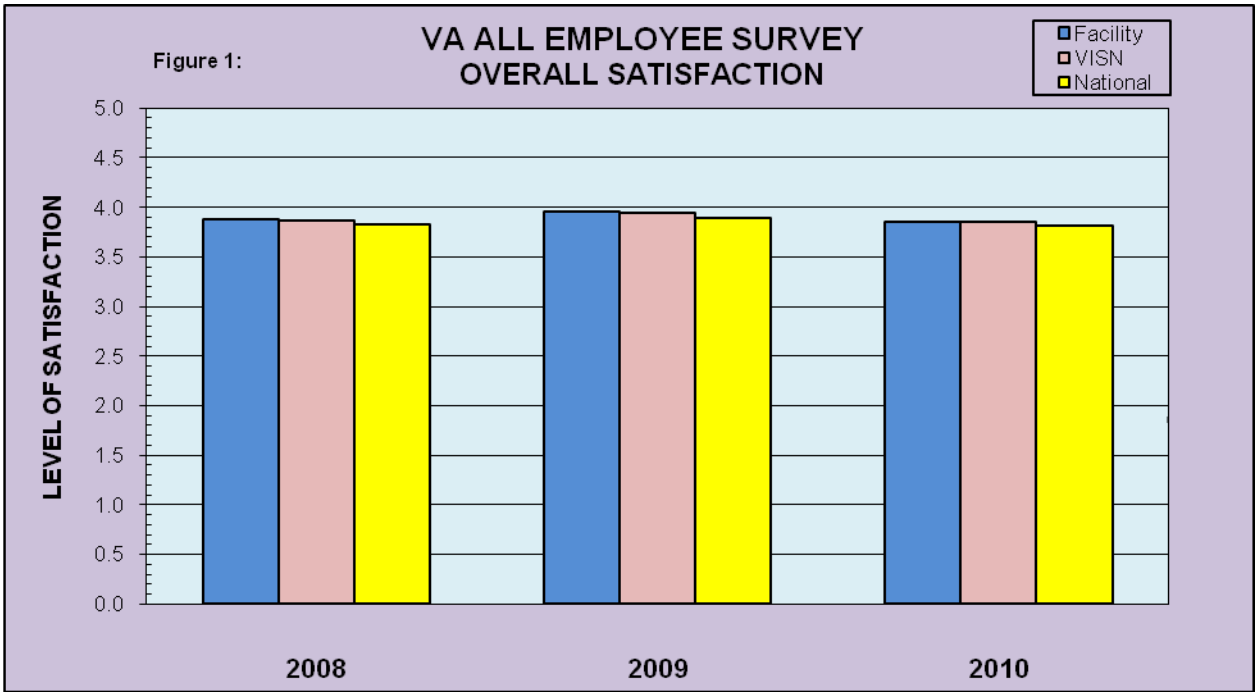
VHA has identified patient and employee satisfaction scores as significant indicators of facility performance. Patients are surveyed monthly. Table 1 below shows facility, VISN, and VHA overall inpatient and outpatient satisfaction scores and targets for FY 2010.

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	63.6	67.1	69.5	74.0	54.9	53.7	62.8	53.7
VISN	64.5	63.6	67.4	68.1	56.5	56.9	59.2	57.2
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[9] 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	12.18	7.74	11.22	20.05	19.26	16.05
VHA	13.31	9.73	15.08	20.57	21.71	15.85

[9] 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: August 12, 2011

From: Director, VA Midwest Health Care Network (10N23)

Subject: **CAP Review of the Minneapolis VA Health Care System, Minneapolis, MN**

To: Director, Chicago Office of Healthcare Inspections (54CH)

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

I have reviewed the findings and recommendations to the OIG CAP conducted at the Minneapolis VA Health Care System. I concur with the facility response and action plans to the Healthcare Inspection report.

Janet P. Murphy, MBA

Facility Director Comments

Department of Veterans Affairs **Memorandum**

Date: August 12, 2011

From: Director, Minneapolis VA Health Care System (618/00)

Subject: **CAP Review of the Minneapolis VA Health Care System, Minneapolis, MN**

To: Director, VA Midwest Health Care Network (10N23)

Thank you for the opportunity to review the draft report of recommendations from the OIG CAP conducted at the Minneapolis VA Health Care System. I have reviewed the report from the site visit that occurred during the week of June 13th–17th, 2011. I concur with the recommendations and we have already initiated corrective actions.

If you have any questions regarding our responses and actions to the recommendations in the report, please contact me at (612) 725.2101.

STEVEN P. KLEINGLASS
Medical Center Director, Minneapolis

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 processes be strengthened to ensure that emergency medications in tackle boxes are monitored for expiration dates and that expired medications are removed.

Concur

Target date for completion: December 31, 2011

Staff in Spinal Cord Injury Center properly disposed of the noted medications during the site visit. A process has been implemented to ensure the emergency medications in the tackle boxes are monitored monthly for expiration dates and removed. This will be monitored by SCI management monthly for six months and reported out to the Executive Committee of the Nursing Staff (ECONS).

Recommendation 2. We recommended that vaginal speculums be maintained in sterile packaging until used.

Concur

Target date for completion: December 31, 2011

SPD began packaging vaginal speculums individually to ensure proper storage prior to utilization during the site visit. Visual checks will be made randomly by SPD to ensure that the process is consistent. Audit results will go to the Reusable Medical Equipment Committee (RMEC) monthly through December 2011

Recommendation 3. We recommended that annual OSHA bloodborne pathogens training and N95 respirator fit testing be completed and that compliance be monitored.

Concur

Target date for completion: December 31, 2011

Policy review will be conducted to ensure that staff requiring annual N95 fit-testing are identified, trained and fit-tested. Annual reports of completion will be monitored. OSHA blood borne pathogens training will be completed by all appropriate staff, with monitoring established through Surveillance, Prevention, and Control of Infection Committee (SPCIC) quarterly.

Recommendation 4. We recommended that all PRs be completed within the 120-day timeframe or have an extension that is approved in writing by the facility Director prior to the 120-day deadline.

Concur

Target date for completion: December 31, 2011

A process was implemented to ensure all PRs are completed within the 120-day timeframe at the time this was noted on the site visit. Requests for Director approved extensions are now tracked and monitored quarterly through the Chief of Staff and the Executive Committee of the Medical Center (ECMS) to ensure compliance.

Recommendation 5. We recommended that processes be strengthened to ensure that moderate sedation documentation includes a review of current medications and evidence the patient was discharged in the company of a responsible, designated adult and that compliance is monitored.

Concur

Target date for completion: December 31, 2011

Moderate sedation documentation template will be changed to include a review of current medications; notation to include discharge in the company of a responsible, designated adult; and a chart audit to monitor compliance via Moderate Sedation Committee.

Recommendation 6 . We recommended that the CPR/Rapid Response Team Subcommittee review each resuscitation event and analyze all required data elements.

Concur

Target date for completion: December 31, 2011

A process was re-established during the site visit to include a review of each resuscitation event by the CPR/Rapid Response Team Subcommittee. Analysis of required elements are now tracked, monitored and reported to ECMS on a quarterly basis. Reports will be audited to ensure that all required items are present through December 2011 through the CPR Committee.

Recommendation 7 . We recommended that the facility AD policy be updated to comply with VHA policy.

Concur

Target date for completion: December 31, 2011

The facility AD policy will be reviewed and updated to comply with VHA policy.

Recommendation 8. We recommended that processes be strengthened to ensure that all components of written AD notification are provided to patients and that AD notification and screening are documented in the medical record.

Concur

Target date for completion: December 31, 2011

The facility AD policy will be updated to comply with VHA policy to include components of written advance directive notification to patients, and document AD notification and screening in the medical record. Quarterly audits will be reviewed in Medical Records Committee.

Recommendation 9. We recommended that processes be strengthened to ensure that physician clinical privileges are service/setting specific.

Concur

Target date for completion: December 31, 2011

Privilege forms used by providers will be revised. These revisions will ensure that only privileges appropriate to the setting in which providers are practicing may be granted. Privileges granted will be monitored for the next six months to ensure that privileges granted are appropriate and setting-specific; compliance will be reported to the ECMS at 3 months (October 2011) and 6 months (December 2011).

OIG Contact and Staff Acknowledgments

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