Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 11-01608-273

Combined Assessment Program Review of the G.V. (Sonny) Montgomery VA Medical Center Jackson, Mississippi

September 8, 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

ARB	Accident Review Board
C&P	credentialing and privileging
CAP	Combined Assessment Program
CLC	community living center
CPR	cardiopulmonary resuscitation
DBC	Disruptive Behavior Committee
EMR	electronic medical record
EN	enteral nutrition
EOC	environment of care
facility	G.V. (Sonny) Montgomery VA Medical Center
FY	fiscal year
JC	Joint Commission
MSDS	material safety data sheet
OIG	Office of Inspector General
PRC	Peer Review Committee
PRF	Patient Record Flag
QM	quality management
RN	registered nurse
UOR	uniform offense report
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

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Executive Summary: Combined Assessment Program Review of the G.V. (Sonny) Montgomery VA Medical Center, Jackson, MS

Review Purpose: The purpose was to evaluate selected activities, focusing on patient care administration and quality management, and to provide crime awareness training. We conducted the review the week of June 13, 2011.

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

- Enteral Nutrition Safety
- Medication Management
- Physician Credentialing and Privileging

The facility's reported accomplishments were a program to proactively track patient fluoroscopy exposure and a shortened preoperative testing protocol, which has reduced costs and delays.

Recommendations: We made recommendations in the following five activities:

Management of Workplace Violence: Discuss violent incidents involving employee victims at the Accident Review Board. Ensure that the Disruptive Behavior Committee's (DBC's) decisions to place flags in the medical record are carried out. Share VA police uniform offense reports of workplace violence with the DBC.

Registered Nurse Competencies: Identify actions in facility policy to address registered nurse competency deficiencies. Ensure that competency validation documentation is complete and that the methods used to assess and validate competency are specified. Specify the qualifications required to assess and validate competency.

Quality Management: Include documentation of completed corrective actions in Peer Review Committee minutes. Document risk assessments prior to procedures involving moderate sedation. Ensure all resuscitation events are reviewed and documented in Cardiopulmonary Resuscitation Committee minutes.

Coordination of Care: Ensure advance directive notification and screening are accurately documented. Require advance directives completed on the VA form to be appropriately witnessed.

Environment of Care: Complete annual N95 respirator fit testing for all designated employees. Ensure material safety data sheet inventory lists and hazardous material information are current.

Comments

The Veterans Integrated Service Network and Interim 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:

- Coordination of Care
- 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*

G. V. (Sonny) Montgomery VA Medical Center, Jackson, Mississippi, Report No. 08-03088-138, June 2, 2009). The facility corrected all findings from the prior CAP review. (See Appendix B for further details.)

During this review, we also presented crime awareness briefings for 307 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

Fluoroscopy Tracking

The facility implemented a policy requiring fluoroscopy technicians and their supervisors to track patients exposed to radiation from procedures involving fluoroscopy. In procedures where the radiation dose exceeds 600 rads[1] (far less than the dose required by The JC to be reported) or where the procedure exposure time exceeds 75 minutes, the Radiation Safety Officer is to be notified immediately to make an estimate of patient exposure. Following a report of a case that exceeds either trigger point, the Radiation Safety Officer contacts the patient's provider with instructions to observe the exposed area. The Radiation Safety Officer maintains a file of any resulting after effects. The policy also contains a chart of expected tissue effects and a mechanism to consult dermatology when indicated.

Improved Preoperative Testing Protocol

Anesthesia Service recognized the potential to reduce avoidable costs by shortening the protocol for preoperative testing. By decreasing the numbers of unnecessary preoperative tests, Ophthalmology Service realized a total cost savings of $77,000 for 101 procedures in April and May 2011. In addition to the cost saving benefit, efficiency has improved, and patient travel has been reduced.

[1] A rad is a unit of measurement for absorbed radiation.

Results

Review Activities With Recommendations

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. We selected three assaults that occurred at the facility within the past 2 years, discussed them with managers, and reviewed applicable documents. We identified the following areas that needed improvement.

ARB. VHA policy[2] requires all violent incidents involving employee victims to be discussed at the facility's ARB. Of the three assaults we reviewed, two involved employee injury. Neither was discussed at the ARB.

PRFs. When perpetrators of violence are patients, VHA and facility policy require that the DBC review violent incidents and consider placement of a PRF in the EMR.[3] This flag alerts facility staff about potentially violent patients and may provide instructions about what to do when the patient comes to the facility. Patients were the perpetrators in the three assaults we reviewed. The DBC determined that two of these three patients should have a PRF placed in the EMR. We found that neither of these flags was placed. Therefore, staff were not alerted to the potential danger, and the need for police escort for one of the patients was not communicated to staff.

UORs. Facility policy requires that Police Service complete UORs for incidents involving workplace violence and that these reports be shared with the DBC. We were told that although they were available, UORs had not been shared with the DBC.

Recommendations

1. We recommended that processes be strengthened to ensure that all violent incidents involving employee victims are discussed at the ARB and that compliance is monitored.

2. We recommended that processes be strengthened to ensure that the DBC's decisions to place PRFs in the EMR are carried out and that compliance is monitored.

[2] VHA Handbook 7701.01, *Occupational Safety and Health (OSH) Program Procedures,* August 24, 2010.
[3] VHA Directive 2010-053, *Patient Record Flags,* December 3, 2010 (corrected copy).

3. We recommended that Police Service routinely share UORs for incidents involving workplace violence with the DBC.

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 12 RNs. We identified the following areas that needed improvement.

Facility Competency Validation Process. The JC requires that clinical staff be deemed competent to perform their job responsibilities and that the facility takes action when staff competency does not meet expectations. A competency validation policy or process is required for staff who provide patient care, treatment, or services. The facility's competency validation policy did not clearly identify actions to be taken to correct deficiencies.

Competency Validation Methods and Documentation. The JC requires facilities to specify the assessment methods used (such as test taking, demonstration, or simulation) to determine an individual's competency in required skills. We found that validation methods were not specified for the skill being assessed and validated in 3 of the 12 competency folders reviewed. Additionally, required employee and/or validator signatures were missing in 5 of the 12 folders.

Competency Validation by Qualified Individuals. The JC requires that competency be assessed and validated by an individual with the appropriate education, experience, or knowledge related to the skills being reviewed. Facility processes did not consistently specify the qualifications required for individuals who perform competency assessment and validation.

Recommendations

4. We recommended that facility policy identify actions to be taken when RN competency does not meet expectations.

5. We recommended that processes be strengthened to ensure that RN competency validation documentation is complete and that methods used to assess and validate competency are specified.

6. We recommended that managers specify the qualifications required for individuals who perform RN competency assessment and validation.

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.

Peer Review. VHA requires that all Level 2 and 3 final peer reviews have appropriate actions documented and tracked to closure in PRC meeting minutes.[4] The QM peer review liaison received hand written notices of provider discussions. However, we reviewed 11 cases and found no documentation in the PRC meeting minutes that corrective actions were completed.

Moderate Sedation. VHA requires that providers document a complete history and physical within 30 days prior to an outpatient procedure where moderate sedation will be used and re-evaluate the patient immediately prior to sedation.[5] These evaluations must include a review of overall risk status. We reviewed the EMRs of 10 patients who received moderate sedation and found that 2 EMRs did not contain risk assessments.

CPR Committee. VHA requires that the CPR Committee review each episode of care where resuscitation was attempted and identify opportunities to improve both process and outcomes.[6] We found that the CPR Committee meeting minutes for August 2010 through February 2011 did not reflect a review of individual resuscitation events by the committee.

Recommendations

7. We recommended that processes be strengthened to ensure that PRC minutes include documentation of

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

completed corrective actions and that compliance is monitored.

8. We recommended that processes be strengthened to ensure that risk assessments are documented prior to procedures requiring moderate sedation and that compliance is monitored.

9. We recommended that processes be strengthened to ensure that all resuscitation events are reviewed and documented in CPR Committee meeting minutes and that compliance is monitored.

Coordination of Care

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

We reviewed patients' medical records for evidence of advance directive notification, advance directive 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.

Advance Directive Notification. 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 advance directive.[7] As part of notification, patients must be informed that VA does not discriminate based on whether or not they have an advance directive. We reviewed the medical records of 20 patients and found that 13 of the records did not contain evidence of all components of written notification. While we were onsite, the facility made changes to progress note templates to better document this process.

Advance Directive Screening Accuracy. VHA requires that staff screen patients at each admission to a VHA facility to determine whether they have an advance directive and document the screening in the medical record.[8] Although advance directive screenings were completed for the 20 patients whose medical records we reviewed, 4 of the screenings were not accurate. These four screenings documented that the patients had completed advance

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

directives and that they were scanned into the medical record. However, we could not locate any of these advance directives.

Management of Advance Directive Documents. VHA requires the signature of two witnesses when advance directives are executed on the VA form.[9] We examined five advance directives completed on the VA form and found that one was not witnessed properly.

Recommendation

10. We recommended that processes be strengthened to ensure that all components of advance directive notification are documented, that advance directive screening is accurately documented in the EMR, and that advance directives completed on the VA form are appropriately witnessed.

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 inpatient surgical, medical/surgical, and medical/telemetry/oncology units; the acute locked mental health unit; one CLC unit; and the intensive care units. We also inspected the emergency department, the same day surgery and post-anesthesia areas, the cardiac catheterization suite, the oncology clinic, the dialysis unit, and the offsite dental clinics. The facility maintained a generally clean and safe environment. However, we identified the following conditions that needed improvement.

Infection Control. The Occupational Safety and Health Administration requires that facilities using N95 respirators fit test designated employees annually. We reviewed 33 employee records and determined that 21 (64 percent) designated employees did not have the required annual fit testing.

Environmental Safety. The Occupational Safety and Health Administration and The JC require that facilities maintain current MSDS inventory lists and hazardous material information for chemicals used in clinical areas. We reviewed 14 MSDS inventory lists and found that 5 were not current and did not contain all required information.

[9] VHA Handbook 1004.02.

Recommendations

11. We recommended that N95 respirator fit testing be completed annually for designated employees and that compliance be monitored.

12. We recommended that processes be strengthened to ensure that MSDS inventory lists and hazardous material information are current and contain all required information.

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 15 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.

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/chemotherapy clinic, and we interviewed employees. We determined that the facility safely prepared, transported, and administered the medications. We made no recommendations.

Physician C&P

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

We reviewed 22 C&P files and profiles and meeting minutes during which discussions about the physicians took place. We determined that the facility had implemented a consistent C&P process that met current requirements. We made no recommendations.

Comments

The VISN and Interim Facility Directors agreed with the CAP review findings and recommendations and provided acceptable improvement plans. See Appendixes D and E, pages 15–20, for the full text of the Directors' comments. We will follow up on the planned actions until they are completed.

Facility Profile[10]		
Type of Organization	Tertiary care facility	
Complexity Level	1b	
VISN	16	
Community Based Outpatient Clinics	Columbus, MS Greenville, MS Hattiesburg, MS Kosciusko, MS McComb, MS Meridian, MS Natchez, MS	
Veteran Population in Catchment Area	108,436	
Type and Number of Total Operating Beds: • **Hospital, including Psychosocial Residential Rehabilitation Treatment Program**	155 total (128 hospital, 27 residential)	
• **CLC/Nursing Home Care Unit**	86	
Medical School Affiliation(s)	University of Mississippi	
• **Number of Residents**	42.5	
	FY 2011 (through March 2011)	**Prior FY (2010)**
Resources (in millions):		
• **Total Medical Care Budget**	$263	$215
• **Medical Care Expenditures**	$173	$215
Total Medical Care Full-Time Employee Equivalents	1,860	1,865
Workload:		
• **Number of Station Level Unique Patients**	38,631	44,715
• **Inpatient Days of Care:**		
o **Acute Care**	15,802	31,561
o **CLC/Nursing Home Care Unit**	13,176	36,624
Hospital Discharges	2,667	5,391
Total Average Daily Census (including all bed types)	86.8	86.5
Cumulative Occupancy Rate (in percent)	67.8	67.6
Outpatient Visits	230,425	456,282

[10] 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 that mechanisms are in place to adequately evaluate and disclose adverse events in accordance with VHA policy.	Facility consulted with VA Central Office to clarify what is required and now discloses all known complications.	Y	N
2. Fully document PRC discussions in committee minutes.	Peer Review Coordinator implemented changes to the structure of committee minutes.	Y	N
3. Complete peer reviews within the required timelines.	Peer Review Coordinator tracks reviews for timeliness and coordinates with VISN as needed for timely external reviews.	Y	N
EOC			
4. Secure medication room in the post-anesthesia care unit.	Post-anesthesia care unit location added to daily nursing supervisor rounds.	Y	N
5. Clean air ventilation outlets in the CLC and on Ward 4CS according to standard operating procedures.	A schedule was developed for cleaning air vents in all areas of the facility.	Y	N
6. Maintain cleanliness of the dialysis unit.	There is a regular daily schedule for cleaning the unit.	Y	N
Medication Management			
7. Document effectiveness of as needed medications.	Monitored monthly at Clinical Informatics Committee. Recent audits show 95–96 percent compliance.	Y	N

Recommendations	Current Status of Corrective Actions Taken	In Compliance Y/N	Repeat Recommendation? Y/N
Suicide Safety Plans			
8. Comply with VHA regulations regarding documentation of safety plans for patients deemed at high risk for suicide.	Documentation of suicide prevention safety plans occurs at hospital discharge. Suicide Prevention Coordinator tracks compliance on data dashboard.	Y	N

VHA Satisfaction Surveys

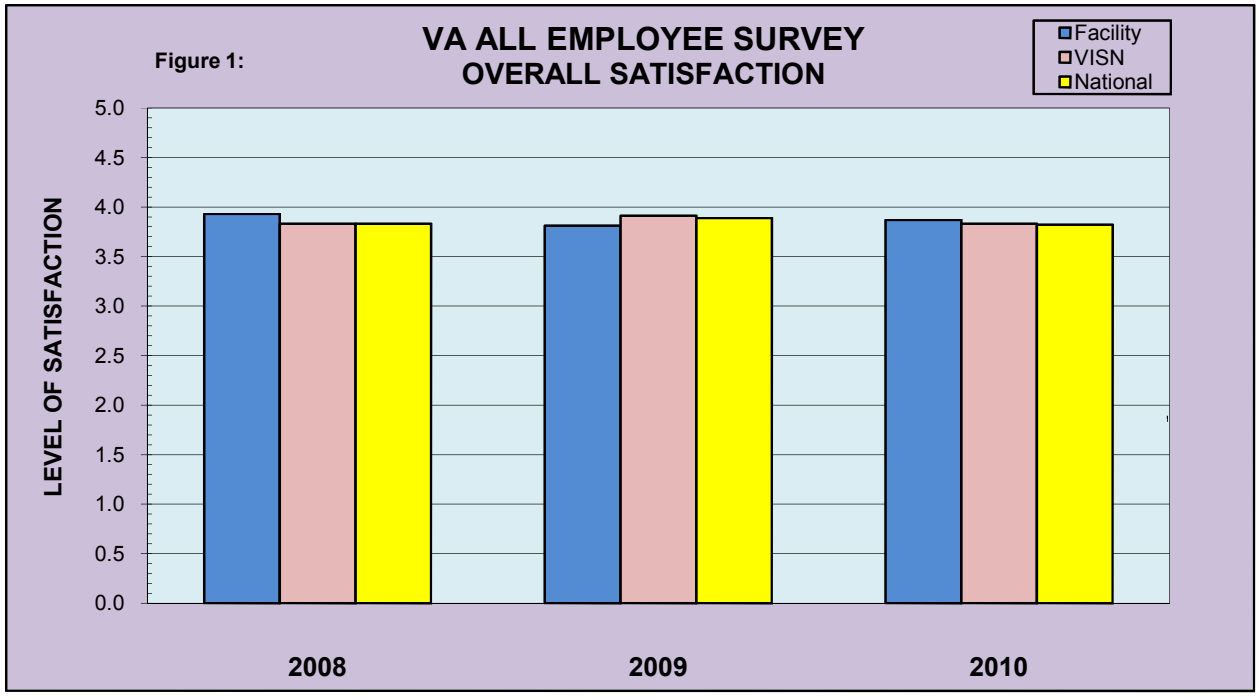
VHA has identified patient and employee satisfaction scores as significant indicators of facility performance. Patients are surveyed monthly. Table 1 below shows facility, VISN, and VHA overall inpatient and outpatient satisfaction scores and targets for FY 2010.

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	61.7	60.5	70.8	68.7	57.1	56.8	56.1	49.4
VISN	66.1	64.6	63.1	61.8	53.1	54.3	54.6	50.8
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[11] 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	16.52	12.34	21.41	20.71	20.93	16.96
VHA	13.31	9.73	15.08	20.57	21.71	15.85

[11] 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, South Central VA Health Care Network (10N16)

Subject: **CAP Review of the G.V. (Sonny) Montgomery VA Medical Center, Jackson, MS**

To: Director, Bay Pines Office of Healthcare Inspections (54SP)

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

1.&I have reviewed the attached draft management report and concur with the recommendations and actions.

2.&If you have any questions regarding the response, please contact Mary Jones, HSS at 601-206-6974.

(original signed by:)
GEORGE H. GRAY, JR.
Director, South Central VA Health Care Network (10N16)

Interim Facility Director Comments

Department of Veterans Affairs **Memorandum**

Date: August 12, 2011

From: Interim Director, G.V. (Sonny) Montgomery VA Medical Center (586/00)

Subject: **CAP Review of the G.V. (Sonny) Montgomery VA Medical Center, Jackson, MS**

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

1.&Enclosed are the responses to the recommendations in the draft report: Combined Assessment Program Review, G.V. Sonny Montgomery VA Medical Center, Jackson, MS.

2.&If you have any questions or would like to discuss the report, please contact me at (601) 364-1204.

(original signed by:)
SHANNON NOVOTNY'
Acting Center Director, G. V. (Sonny) Montgomery VA Medical Center'

Comments to Office of Inspector General's Report

The following Interim 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 all violent incidents involving employee victims are discussed at the ARB and that compliance is monitored.

Target date for completion: September 1, 2011

Concur: The ARB will discuss all violent incidents involving employee victims entered into the Automated Safety Incident Surveillance and Tracking System during quarterly meetings. Safety Officer/Designee will ensure minutes capture discussion of each Automated Safety Incident Surveillance and Tracking System incident.

Recommendation 2. We recommended that processes be strengthened to ensure that the DBC's decisions to place PRFs in the EMR are carried out and that compliance is monitored.

Target date for completion: August 31, 2011

Concur: Upon determination that a Patient Record Flag (PRF) be placed, it will be entered during the Disruptive Behavior Committee (DBC) meeting. In addition, the DBC has developed a spreadsheet to track documentation of all elements of patient record flag placement. Compliance will be monitored through the DBC minutes, and the spreadsheet. The DBC policy will also be revised to state that during emergencies the COS/designee may immediately approve PRF placements in the EMR.

Recommendation 3. We recommended that Police Service routinely share UORs for incidents involving workplace violence with the DBC.

Target date for completion: August 3, 2011

Concur: The Police Chief/Designee is now submitting the Uniform Offense Report to the Disruptive Behavior Committee monthly. The data is now captured and tracked in DBC minutes and is a standing agenda item.

Recommendation 4. We recommended that facility policy identify actions to be taken when RN competency does not meet expectations.

Target date for completion: August 31, 2011

Concur: The Competency Assessment Policy K-05-26 will be revised to include the actions that will be taken when an individual does not meet competency expectations.

Recommendation 5. We recommended that processes be strengthened to ensure that RN competency validation documentation is complete and that methods used to assess and validate competency are specified.

Target date for completion: August 15, 2011

Concur: One hundred percent of the folders assessed during the RN Competency Review that required actions were corrected by the appropriate Head Nurse and reviewed by the Deputy Associate Director for Patient Care Services for 2A, SICU and 1st Floor CLC. Deputy Associate Director for Patient Care Services for units 2A, SICU, and 1st Floor CLC will continue to monitor competency folders quarterly to ensure all documentation is complete including validation methods and signatures.

Recommendation 6. We recommended that managers specify the qualifications required for individuals who perform RN competency assessment and validation.

Target date for completion: August 31, 2011

Concur: The Competency Assessment Policy K-05-26 will be revised to include a process for Managers/Supervisors to identify those who are competent to assess the competency of others.

Recommendation 7. We recommended that processes be strengthened to ensure that PRC minutes include documentation of completed corrective actions and that compliance is monitored.

Target date for completion: July 1, 2011

Concur: The peer review process has been strengthened to ensure documentation of corrective action completion is included in the Peer Review Committee minutes.

Recommendation 8. We recommended that processes be strengthened to ensure that risk assessments are documented prior to procedures requiring moderate sedation and that compliance is monitored.

Target date for completion: August 31, 2011

Concur: The facility policy has been revised to ensure that Anesthesiologists or Certified Registered Nurse Anesthetists complete the risk assessment if it has not been completed by the provider prior to initiating a procedure with moderate sedation. If the procedure does not require an Anesthesiologist or Certified Registered Nurse Anesthetist, the provider performing the procedure will be responsible for completing the risk assessments. Compliance will be monitored quarterly by the Procedure Review Committee.

Recommendation 9. We recommended that processes be strengthened to ensure that all resuscitation events are reviewed and documented in CPR Committee meeting minutes and that compliance is monitored.

Target date for completion: June 29, 2011

Concur: The CPR Committee minutes have been revised to reflect review of individual resuscitation events. The Code spreadsheet is now embedded within the committee minutes along with a summary of the resuscitation events.

Recommendation 10. We recommended that processes be strengthened to ensure that all components of advance directive notification are documented, that advance directive screening is accurately documented in the EMR, and that advance directives completed on the VA form are appropriately witnessed.

Target date for completion: August 31, 2011

Concur: The Advance Directive notification process was strengthened to reflect the current VHA Directive. The facility made changes to the advance directive progress note templates in the electronic medical record during the survey to include all components required for written documentation of advance directive notification. Providers were educated on this change on June 17, 2011. A Systems Redesign Team is revising the facility Advance Care Planning policy to delineate all components of documentation required during advance directive notification. Training programs are currently being developed for each discipline involved in the advance care planning process. The updated policy will emphasize the requirement for two witnesses when advance directives are executed.

Recommendation 11. We recommended that N95 respirator fit testing be completed annually for designated employees and that compliance be monitored.

Target date for completion: August 1, 2011

Concur: FMS has developed a spreadsheet for tracking the N95 Fit Testing program. Services are now required to compile a list of employees for testing and referral to Employee Health for a screening prior to fit testing. The employee's Service will then contact FMS to schedule fit testing. FMS will maintain the facility spreadsheet and notify services when annual N95 Fit Testing is due.

Recommendation 12. We recommended that processes be strengthened to ensure that MSDS inventory lists and hazardous material information are current and contain all required information.

Target date for completion: August 31, 2011

Concur: FMS has created a spreadsheet to track and monitor updates of MSDS annually.

OIG Contact and Staff Acknowledgments

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