Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 11-02079-287

Combined Assessment Program Review of the West Texas VA Health Care System Big Spring, Texas

September 21, 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

C&P	credentialing and privileging
CAP	Combined Assessment Program
EN	enteral nutrition
EOC	environment of care
facility	West Texas VA Health Care System
FY	fiscal year
MEC	Medical Executive Committee
MH RRTP	Mental Health Residential Rehabilitation Treatment Program
OIG	Office of Inspector General
PSB	Professional Standards Board
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 West Texas VA Health Care System, Big Spring, TX

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 July 11, 2011.

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

- Coordination of Care
- Management of Workplace Violence

Recommendations: We made recommendations in the following five activities:

Quality Management: Ensure all required members attend assigned committee meetings. Ensure that all required components of pre-sedation assessments are documented prior to sedation and that compliance is monitored. Ensure that all required components are included in resuscitation event reviews and medical records reviews and that compliance is monitored.

Enteral Nutrition Safety: Ensure enteral nutrition documentation includes all required elements.

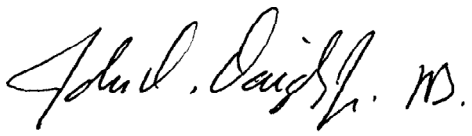
Environment of Care: Ensure that annual bloodborne pathogens training is completed and that compliance is monitored. Ensure that all laser operators comply with the facility laser safety policy. Require that Mental Health Residential Rehabilitation Treatment Program inspections are conducted at required intervals, include all elements, and are documented.

Physician Credentialing and Privileging: Ensure that the Professional Standards Board submits actions and recommendations for privileging and reprivileging to the Medical Executive Committee and that Medical Executive Committee meeting minutes include documentation of reviews and decisions.

Registered Nurse Competencies: Ensure competency validation documentation is complete and specifies the methods used to assess and validate competency.

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
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Objectives and Scope

Objectives

CAP reviews are one element of the OIG's efforts to ensure that our Nation's veterans receive high quality VA health care services. The objectives of the CAP review are to:

- Conduct recurring evaluations of selected health care facility operations, focusing on patient care administration and QM.
- Provide crime awareness briefings to increase employee understanding of the potential for program fraud and the requirement to refer suspected criminal activity to the OIG.

Scope

We reviewed selected clinical and administrative activities to evaluate the effectiveness of patient care administration and QM. Patient care administration is the process of planning and delivering patient care. QM is the process of monitoring the quality of care to identify and correct harmful and potentially harmful practices and conditions.

In performing the review, we inspected selected areas, interviewed managers and employees, and reviewed clinical and administrative records. The review covered the following seven activities:

- Coordination of Care
- EN Safety
- EOC
- Management of Workplace Violence
- Physician C&P
- QM
- RN Competencies

The review covered facility operations for FY 2010 and FY 2011 through July 8, 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 West Texas VA Health Care System, Big Spring, Texas,* Report No. 08-03043-70,

February 19, 2009). The facility had corrected all previous findings. (See Appendix B for further details.)

During this review, we also presented crime awareness briefings for 63 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.

Results

Review Activities With Recommendations

QM

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

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

QM Oversight. VHA requires each facility to provide oversight to ensure that QM components are implemented, integrated, and documented.[1] The facility used the Quality Executive Board to provide oversight of clinical activities. We found that required members did not regularly attend assigned committee meetings. We reviewed minutes from October 2009–March 2011 and found that two required members of senior leadership did not attend any meetings during this period. We also reviewed Infection Prevention and Wellness Committee minutes from October 2010–April 2011 and found that 3 of the 16 required members did not attend any meetings during this period.

Moderate Sedation. VHA requires that a licensed independent practitioner complete a pre-sedation assessment that includes all required components prior to patient sedation.[2] We reviewed the medical records of 10 patients who received moderate sedation and found

[1] VHA Directive 2009-043, *Quality Management System*, September 11, 2009.
[2] VHA Directive 2006-023, *Moderate Sedation by Non-Anesthesia Providers*, May 1, 2006.

5 pre-sedation assessments where the licensed independent practitioner did not document all the required components, such as airway or risk assessment.

Resuscitation and Its Outcomes. VHA requires that facilities have a designated Cardiopulmonary Resuscitation Committee to evaluate each resuscitation event using specific review components.[3] While reviews of resuscitation events were completed, the reviews did not include all the required components, such as errors or deficiencies in technique and delays in initiating cardiopulmonary resuscitation.

Medical Record Review. VHA requires facilities to conduct medical record reviews that include specific areas of review.[4] While medical record quality reviews had been completed, we found that they did not include all of the required components. For example, we found that the facility did not review a representative sample of records from each program/service area and did not monitor unauthenticated documentation.

Recommendations

1. We recommended that processes be strengthened to ensure that all required members attend assigned committee meetings.

2. We recommended that processes be strengthened to ensure that all required components of the pre-sedation assessment are documented by the licensed independent practitioner prior to sedation and that compliance is monitored.

3. We recommended that resuscitation event review processes be strengthened to ensure that all required components are included and that compliance is monitored.

4. We recommended that medical record review processes be strengthened to ensure that all required components are included and that compliance is monitored.

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.

[3] VHA Directive 2008-063, *Oversight and Monitoring of Cardiopulmonary Resuscitative Events and Facility Cardiopulmonary Resuscitation Committees*, October 17, 2008.
[4] VHA Handbook 1907.01, *Health Information Management and Health Records*, August 25, 2006.

We reviewed policies and documents related to EN and patients' medical records. We inspected areas where EN products were stored while conducting the EOC review, and we interviewed key employees. We identified the following area that needed improvement.

EN Documentation. VHA requires that staff document specific EN information in patients' medical records.[5] We reviewed the medical records of 11 EN patients and found that 2 records did not contain all required information. For example, neither record included documentation of x-ray confirmation of Dobhoff tube[6] placement.

Recommendation

5. We recommended that processes be strengthened to ensure that EN documentation includes 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 and whether the facility's domiciliary was in compliance with selected MH RRTP requirements.

We inspected the medical-surgical unit; the community living center; the urgent care, primary care, ophthalmology, and dental clinics; the day procedure unit; and the domiciliary. 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 employees with occupational exposure risk receive annual training on the Occupational Safety and Health Administration Bloodborne Pathogens Rule. We reviewed 25 employee training records and found that 10 employees did not have this training documented.

Laser Safety. Local policy requires that all laser procedures are performed in the ophthalmology clinic and that laser users are credentialed physicians or nurses. We found that physical therapists had been operating lasers in the Physical Therapy Department.

MH RRTP Inspections. VHA requires facilities to conduct and document monthly MH RRTP self-inspections that

[5] VHA Handbook 1109.05, *Specialized Nutritional Support*, May 10, 2007.
[6] A Dobhoff tube is a feeding tube that is inserted in the nose and goes through the throat into the stomach.

include safety, security, and privacy.[7] VHA also requires that MH RRTP staff conduct and document public area inspections for contraband regularly and randomly, resident room inspections for unsecured medications daily and randomly, and public area inspections for safety and security every 2 hours. We found that monthly self-inspections did not include security and privacy. Additionally, we did not find documentation of inspections of public areas for contraband, random inspections of resident rooms for unsecured medications, or inspections of public areas every 2 hours.

Recommendations

6. We recommended that annual bloodborne pathogens training be completed and that compliance be monitored.

7. We recommended that processes be strengthened to ensure that all laser operators comply with the facility laser safety policy.

8. We recommended that processes be strengthened to ensure that all MH RRTP inspections are conducted at required intervals, include all elements, and are documented.

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.

MEC Oversight of PSB. VHA requires that PSB actions and recommendations be submitted to the MEC for review and approval.[8] MEC meeting minutes did not include documentation of the review or approval of PSB privileging or reprivileging recommendations prior to granting privileges for the 15 physicians whose folders we reviewed.

Recommendation

9. We recommended that the PSB submit actions and recommendations for privileging and reprivileging to the MEC and that MEC meeting minutes include documentation of reviews and decisions.

[7] VHA Handbook 1162.02, *Mental Health Residential Rehabilitation Treatment Program (MH RRTP)*, May 26, 2009.
[8] VHA Handbook 1100.19, *Credentialing and Privileging*, November 14, 2008.

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 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.

Competency Validation Documentation. The Joint Commission requires that nursing personnel are competent to perform their responsibilities. Eight RN competency folders had documentation deficiencies. The RN assessing competency did not sign and date each competency individually as required by the form.

Competency Validation Methods. The Joint Commission requires facilities to specify the assessment methods used (such as test taking, demonstration, or simulation) to determine an individual's competency in required skills. Additionally, local policy requires validation of each skill listed in the RN's competency folder. Seven of the RN competency folders reviewed did not have reviewer documentation of the assessment methods for the skills listed.

Recommendation

10. We recommended that processes be strengthened to ensure that competency validation documentation is complete and specifies the methods used to assess and validate competency.

Review Activities Without Recommendations

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 and the facility's advance care planning policy and determined that the facility generally met VHA requirements. We made no 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. 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.

Comments

The VISN and Facility Directors agreed with the CAP review findings and recommendations and provided acceptable improvement plans. (See Appendixes D and E, pages 13–18, for the full text of the Directors' comments.) We consider Recommendation 10 closed. We will follow up on the planned actions for the open recommendations until they are completed.

Facility Profile[9]		
Type of Organization	Veterans Rural Access Hospital	
Complexity Level	3	
VISN	18	
Community Based Outpatient Clinics	Abilene, TX Odessa, TX San Angelo, TX Hobbs, NM Ft. Stockton, TX (outreach clinic) Stamford, TX (outreach clinic)	
Veteran Population in Catchment Area	70,000	
Type and Number of Total Operating Beds: • **Hospital, including Psychosocial Residential Rehabilitation Treatment Program**	20	
• **Community Living Center/Nursing Home Care Unit**	40	
• **Other**	12 (domiciliary)	
Medical School Affiliation(s)	Texas Tech University	
• **Number of Residents**	4	
	Current FY (through March 2011)	**Prior FY (2010)**
Resources (in millions):		
• **Total Medical Care Budget**	$92.6	$94.8
• **Medical Care Expenditures**	$44.5	$93.1
Total Medical Care Full-Time Employee Equivalents	548	549
Workload:		
• **Number of Station Level Unique Patients**	14,091	17,321
• **Inpatient Days of Care:**		
o **Acute Care**	534	1,968
o **Community Living Center/Nursing Home Care Unit**	6,345	12,282
Hospital Discharges	130	433
Total Average Daily Census (including all bed types)	49.5	50.2
Cumulative Occupancy Rate (in percent)	61.89	68.80
Outpatient Visits	70,954	148,248

[9] 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 root cause analyses are completed within 45 days.	The Patient Safety Manager monitors progress of individual and aggregate root cause analyses to completion. All root cause analyses chartered since March 2008 have been completed within 45 days or less.	Y	N
2. Ensure that medical records are reviewed on an ongoing basis at the point of care by providers who document in the record, in accordance with VHA policy.	The Ongoing Professional Practice Evaluation plan was written and implemented after the CAP and has been maintained.	Y	N
3. Ensure that the copy and paste function in the electronic medical record is monitored to identify violations, in accordance with local policy.	Provider medical record entries are reviewed on a monthly basis at the point of care for clinical pertinence, quality, and appropriateness of care. Review results are reported to the Medical Records Committee monthly and to the Quality Executive Board quarterly.	Y	N
Medication Management			
4. Ensure that clinicians document pain medication effectiveness in a timely manner.	Review of documentation of pain effectiveness monitors was at or above a collective score of 90 percent for the previous 12 months.	Y	N

Recommendations	Current Status of Corrective Actions Taken	In Compliance Y/N	Repeat Recommendation? Y/N
EOC			
5. Ensure that identified EOC deficiencies are corrected.	Follow-up EOC rounds take place 11 days after initial report to check for completion. Service chiefs receive weekly progress reports on the correction of EOC deficiencies. The 85 percent completion target has been met since the 4th quarter of FY 2008.	Y	N
Pharmacy Operations and Controlled Substance Inspections			
6. Ensure that monthly controlled substances inspections are completed the day initiated.	Controlled substance inspections for the past 2 years were all completed on the day initiated.	Y	N
Emergency/Urgent Care Operations			
7. Ensure that RNs who work in the urgent care clinic achieve the required clinical competencies annually.	All annual RN competencies for the urgent care clinic are in compliance.	Y	N

VHA Satisfaction Surveys

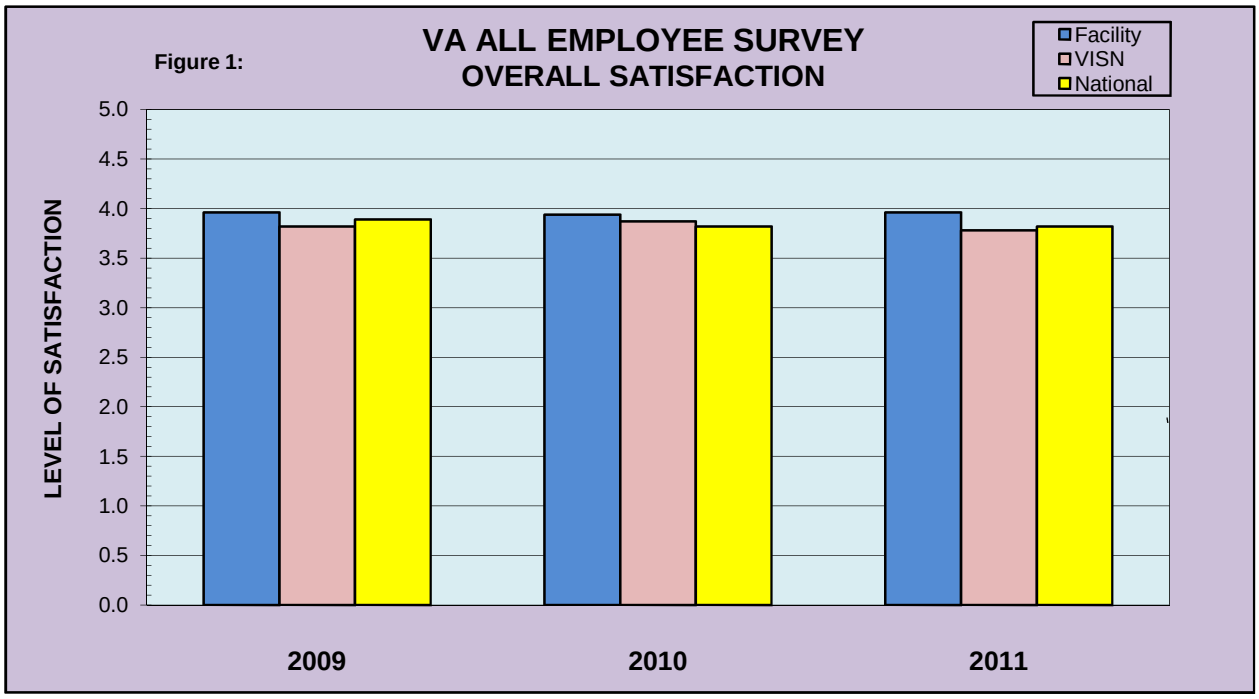
VHA has identified patient and employee satisfaction scores as significant indicators of facility performance. Patients are surveyed monthly. Table 1 below shows facility, VISN, and VHA overall inpatient and outpatient satisfaction scores and targets for quarters 3 and 4 of FY 2010 and quarters 1 and 2 of FY 2011.

Table 1

	FY 2010			FY 2011		
	Inpatient Score Quarters 3–4	Outpatient Score Quarter 3	Outpatient Score Quarter 4	Inpatient Score Quarters 1–2	Outpatient Score Quarter 1	Outpatient Score Quarter 2
Facility	65.5	51.0	53.0	69.8	44.2	45.5
VISN	64.1	53.1	52.8	64.6	52.5	52.0
VHA	64.1	54.8	54.4	63.9	55.9	55.3

Employees are surveyed annually. Figure 1 below shows the facility's overall employee scores for 2009, 2010, and 2011. 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[10] 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	*	9.29	16.86	*	21.08	14.73
VHA	13.31	9.73	15.08	20.57	21.71	15.85

* Not enough cases

[10] 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 26, 2011

From: Network Director, VISN 18 (10N18)

Subject: **CAP Review of the West Texas VA Health Care System, Big Spring, TX (519/00)**

To: Director, Dallas Office of Healthcare Inspections (54DA)

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

I concur with the recommendations for improvement contained in the Combined Assessment Program review at the West Texas VA Health Care System. If you have any questions or concerns, please contact Sally Compton, Executive Assistant to the Network Director, VISN 18, at 602-222-2699.

(original signed by:)
Susan P. Bowers

Facility Director Comments

Department of Veterans Affairs **Memorandum**

Date: August 22, 2011

From: WTVAHCS Facility Director

Subject: **CAP Review of the West Texas VA Health Care System, Big Spring, TX (519/00)**

To: Director, VA Southwest Health Care Network (10N18)

I concur with the attached facility update on the recommendations for improvement contained in the Combined Assessment Program review at the West Texas VA Health Care System. If you have any questions or concerns, please contact Rosa Mancha, Quality Manager, WTVAHCS at 432 264-4832.

(original signed by:)
Mr. Daniel L. Marsh
Director, West Texas VA Healthcare System (519/00)

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 all required members attend assigned committee meetings.

Concur

Target date for completion: September 30, 2011

Quality Management will add a component to monitor committee meeting attendance to the committee minute review checklist and will provide a summary of facility committee attendance to the Quality Executive Board.

Recommendation 2. We recommended that processes be strengthened to ensure that all required components of the pre-sedation assessment are documented by the licensed independent practitioner prior to sedation and that compliance is monitored.

Concur

Target date for completion: September 30, 2011

The pre-sedation assessment template was updated to include the American Society of Anesthesiology preoperative assessment and the Mallampati airway classification. Education has been provided to the contract provider by the Chief of Medicine. The licensed provider and a nursing representative will review all records of patients that require sedation to assure all documentation is provided. Their findings will be presented monthly to the Operative and Invasive Procedure Review Committee.

Recommendation 3. We recommended that resuscitation event review processes be strengthened to ensure that all required components are included and that compliance is monitored.

Concur

Target date for completion: September 30, 2011

The code evaluation sheet was updated by the Monitored Care Unit/Cardio Pulmonary Resuscitation (MCU/CPR) Committee to include required components such as errors or deficiencies in technique, and delays in initiating CPR. Education will be provided to nursing staff by the Nurse Educator. MCU/CPR Committee members will be educated by the Committee Chair during the next quarterly MCU/CPR Committee meeting scheduled in September 2011. Physicians will be educated by the Chair, MCU/CPR

Committee during the monthly Medical Staff meeting. The Chair of the MCU/CPR Committee, Urgent Care Nurse Manager and the Risk Manager will review 100 percent of Code Blues within 72 hours to assure all documentation is provided. MCU/CPR Committee meetings will be held at the call of the Risk Manager to address urgent findings and opportunities for improvements. Findings and trends will be documented in the MCU/CPR minutes.

Recommendation 4. We recommended that medical record review processes be strengthened to ensure that all required components are included and that compliance is monitored.

Concur

Target date for completion: September 30, 2011

The Chief of Health Information Management Section will run a monthly report to monitor 100 percent of unauthenticated-unsigned notes. Correction will be requested from providers, and non-compliance will be referred to Service Chiefs for follow up and appropriate action. Results will be presented to the Medical Record Review Committee. Reviews will include a random sample from each service area. In addition, required review elements are included in the Ongoing Professional Practice Evaluation reviews and reported at the quarterly Medical Record Review Committee for appropriate follow up.

Recommendation 5. We recommended that processes be strengthened to ensure that EN documentation includes all required elements.

Concur

Target date for completion: September 30, 2011

An addendum will be added to the Medicine Service Policy requiring documentation of provider review of nasogastric feeding tube placement. Compliance will be monitored by Chief of Medicine or designee and reported monthly to the Medical Staff.

Recommendation 6. We recommended that annual bloodborne pathogens training be completed and that compliance be monitored.

Concur

Target date for completion: September 16, 2011

Bloodborne pathogen education was designated as mandatory for all employees in the VA's Talent Management System. Percentage of completion will be reported weekly to Executive Leadership with a listing of the individual(s) who are overdue in their training. Results will be forwarded to service chiefs on a weekly basis.

Recommendation 7. We recommended that processes be strengthened to ensure that all laser operators comply with the facility laser safety policy.

Concur

Target date for completion: September 30, 2011

The WTVAHCS laser safety policy will be updated to include Physical Therapists as laser operators to enable the use of laser therapy as a modality in Physical Therapy and ensure that all laser operators comply with the policy.

Recommendation 8. We recommended that processes be strengthened to ensure that all MH RRTP inspections are conducted at required intervals, include all elements, and are documented.

Concur

Target date for completion: August 23, 2011

Chief of Domiciliary Services made immediate changes to the existing tracking process/logs to ensure the appropriate inspections occur as required, within required intervals, and include all elements. Specifically:

1. The Monthly Self-Inspection Log now includes sections on privacy, safety, and security.
2. The DRRTP Bed/Wellness Check/Building Inspection/Daily Rounds process/log was changed to include:
    a. Daily scheduled checks of resident rooms and common/public areas for unsecured medication/contraband.
    b. Daily random unsecured medication/contraband checks of resident rooms and common/public areas.
    c. Regularly scheduled (every 2 hours of all public areas) safety/security checks.
    d. All checks/logs are kept in a DRRTP shared computer drive. DRRTP RN will monitor daily compliance and report weekly to the DRRTP Chief. Monitoring will occur until four successive weeks of full compliance are noted. Random checks will then continue through tracer activity.

Recommendation 9. We recommended that the PSB submit actions and recommendations for privileging and reprivileging to the MEC and that MEC meeting minutes include documentation of reviews and decisions.

Concur

Target date for completion: August 23, 2011

Professional Standards Committee submits recommendations for privileging and re-privileging of providers to the MEC prior to Director approval. MEC minutes now reflect Professional Standards Committee submitted actions and recommendations for MEC review and decision as a standing agenda item.

Recommendation 10. We recommended that processes be strengthened to ensure that competency validation documentation is complete and specifies the methods used to assess and validate competency.

Concur

Target date for completion: August 22, 2011

The nurse educator and nurse managers updated existing nursing competencies to ensure that the RN assessing the competency signed and dated each competency individually as required by the form. The nurse educator and nurse managers updated existing nursing competencies to indicate the method of verification (testing, demonstration, simulation, direct observation, record review, and employee feedback) was documented. Current compliance rate is 98 percent. Nurse managers monitor and report compliance in Nurse Leadership Committee monthly.

OIG Contact and Staff Acknowledgments

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