Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 11-01296-235

Combined Assessment Program Review of the Central Arkansas Veterans Healthcare System Little Rock, Arkansas

August 2, 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.

To Report Suspected Wrongdoing in VA Programs and Operations
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Glossary

C&P	credentialing and privileging
CAP	Combined Assessment Program
CPR	cardiopulmonary resuscitation
EN	enteral nutrition
EOC	environment of care
facility	Central Arkansas Veterans Healthcare System
FY	fiscal year
MEB	Medical Executive Board
OIG	Office of Inspector General
PI	performance improvement
PR	peer review
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 Central Arkansas Veterans Healthcare System, Little Rock, AR

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 May 9, 2011.

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

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

Recommendations: We made recommendations in the following five activities:

Medication Management: Adhere to requirements related to labeling chemotherapy infusions and transport.

Environment of Care: Revise facility medication policy to be consistent with Veterans Health Administration policy. Secure medication, and grant access only to those who distribute or administer medication. Ensure annual bloodborne pathogens training and N95 respirator fit testing are completed, and monitor compliance. Ensure confidential patient information displayed on computer screens is protected from unauthorized access.

Coordination of Care: Ensure all components of written advance directive notification are provided to patients, and document notification. Accurately document patient advance directive screening. Provide advance directive information when requested, and link advance care planning notes to the appropriate posting in the electronic medical record.

Quality Management: Track corrective actions to completion in meeting minutes. Request peer review extensions in writing, and obtain facility Director approval. Ensure the Cardiopulmonary Resuscitation Sub-Committee meets quarterly to evaluate resuscitation events and analyze data.

Physician Credentialing and Privileging: Ensure that the Professional Standards Board submits actions and recommendations for privileging and reprivileging to the Medical Executive Board and that board meeting minutes include review and decision documentation.

Comments

The Veterans Integrated Service Network and Facility Directors agreed with the Combined Assessment Program review findings and recommendations and provided acceptable improvement plans. We will follow up on the planned actions until they are completed.

(original signed by:)

JOHN D. DAIGH, JR., M.D.
Assistant Inspector General for
Healthcare Inspections

Objectives and Scope

Objectives

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

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

Scope

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

In performing the review, we inspected selected areas, interviewed managers and employees, and reviewed clinical and administrative records. The review covered the following 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 May 6, 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 Central Arkansas Veterans*

Healthcare System, Little Rock, Arkansas, Report No. 08-03042-65, February 4, 2009). The facility had corrected all previous findings. (See Appendix B for further details.)

During this review, we also presented crime awareness briefings for 424 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

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 identified the following area that needed improvement.

Preparation and Administration. The American Society of Health-System Pharmacists specifies the necessary personal protective equipment and processes needed for the preparation, transport, and administration of chemotherapy medications. The pharmacy technician we observed preparing an infusion did not clean the chemotherapy gloves prior to affixing the label to the infusion bag. Also, pharmacy staff improperly attempted to remove the infusion bag from the biological safety cabinet before the pharmacy technician placed it in a sealable containment bag for transport.

Recommendation

1. We recommended that processes be strengthened to ensure that staff adhere to requirements related to labeling chemotherapy infusions and transport.

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.

At the Little Rock campus, we inspected medical, surgical, intensive care, same day surgery, and post-anesthesia care units; the emergency department; and a primary care and specialty care clinic. At the North Little Rock campus, we inspected a multipurpose inpatient unit, a mental health inpatient unit, a community living center dementia inpatient unit, a primary care clinic, a mental health clinic, a specialty clinic, and the dental clinic. The facility maintained a generally clean and safe environment. However, we identified the following conditions that needed improvement.

Medication Security. Joint Commission standards require all medications to be secured from access by unauthorized persons. In the primary care clinic medication room at the North Little Rock campus, we found unsecured stock medications. The medication refrigerator was equipped with a lock; however, it was open, and staff reported leaving it unlocked during the day. The medication cabinet was a wall unit that had a pull down door to secure the medications on the shelves with a lock. However, the door would neither pull down nor lock, leaving stock medications on the shelves unsecured. Additionally, the door did not have an automatic closure to prevent unintentionally leaving the door open.

VHA policy requires that access to medication be restricted to staff who distribute or administer medication.[1] Facility policy allowed staff who did not administer or dispense medication to enter medication rooms. At the Little Rock campus, nursing assistants; health technicians; and Supply, Processing, and Distribution technicians were allowed to enter the medication room.

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 37 employee training records and found that 31 (84 percent) employees did not have this training documented.

[1] VHA Handbook 1108.06, *Inpatient Pharmacy Services*, June 27, 2006.

If facilities use N95 respirators, the Occupational Safety and Health Administration requires that designated employees are fit tested annually. We reviewed 15 employee training records and determined that 13 designated employees did not have the required annual fit testing.

Patient Privacy. The Health Insurance Portability and Accountability Act requires confidential patient information to be secured. We found computer screens on two units displaying patient information that could be viewed by those not using the computer as they passed by. Staff using the computers were unaware when someone was standing behind them viewing the information.

Recommendations

2. We recommended that the facility medication policy be revised to be consistent with VHA policy and that processes be strengthened to ensure that medication is secured and that access to medication is granted only to those who distribute or administer medication.

3. We recommended that processes be strengthened to ensure that annual bloodborne pathogens training and N95 respirator fit testing are completed and that compliance is monitored.

4. We recommended that processes be strengthened to ensure that confidential patient information displayed on computer screens is protected from unauthorized access at all times.

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.[2] 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 4 of the records did not contain evidence of all components of written notification.

Advance Directive Screening Accuracy and Follow-Up. 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.[3] Although advance directive screenings were completed for 19 of 20 patients whose medical records we reviewed, 3 of the screenings were not accurate regarding the patients' advance directive status. Further, after screening, two patients requested additional information about advance directives but did not receive any information.

Advance Care Planning Progress Note Titles. VHA requires that staff use specific progress note titles when documenting advance care planning discussions with patients and link these notes to the Crisis, Warning, Allergies and/or Adverse Reactions, and Directives posting in the electronic medical record.[4] We reviewed documentation for 20 patients and determined that 5 records had advance care planning documentation. All five records used the appropriate progress note titles; however, three of the notes were not linked to the Crisis, Warning, Allergies and/or Adverse Reactions, and Directives posting.

Recommendations

5. We recommended that processes be strengthened to ensure that all components of written advance directive notification are provided to patients and that notification is documented in the medical record.

6. We recommended that processes be strengthened to ensure that patient advance directive screening is accurately documented in the medical record and that patients receive additional information when it is requested.

7. We recommended that processes be strengthened to ensure that advance care planning notes are linked to the Crisis, Warning, Allergies and/or Adverse Reactions, and Directives posting.

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

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.[5] The facility's Joint Leadership Council provides oversight of clinical activities through its review of board, committee, and sub-committee minutes; however, documentation in different committee meeting minutes did not always track corrective actions to completion. For example, the MEB recommended a revision to the by-laws without assigning a target date for completion, and we did not find documentation over the subsequent 9 months that the action item was completed.

PR. VHA policy requires facilities to complete a PR within 120 days.[6] Any extension beyond 120 days must be requested in writing from and approved by the facility's Director. Neither of the two PRs that exceeded 120 days had the required written request and approval for extension.

Resuscitation and Its Outcomes. VHA requires facilities to designate a CPR Committee or equivalent to evaluate resuscitation events and analyze data.[7] Local policy designated the CPR Sub-Committee and required it to meet quarterly. The CPR Sub-Committee met only two times between March 2010 and April 2011 and last reviewed resuscitation events in September 2010.

Recommendations

8. We recommended that processes be strengthened to ensure that meeting minutes track corrective actions to completion.

[5] VHA Directive 2009-043, *Quality Management System*, September 11, 2009.
[6] VHA Directive 2010-025, *Peer Review for Quality Management*, June 3, 2010.
[7] VHA Directive 2008-063, *Oversight and Monitoring of Cardiopulmonary Resuscitative Events and Facility Cardiopulmonary Resuscitation Committees*, October 17, 2008.

9. We recommended that processes be strengthened to ensure that PR extensions are requested in writing from and approved by the facility's Director.

10. We recommended that processes be strengthened to ensure that the CPR Sub-Committee meets quarterly to evaluate resuscitation events and analyze data.

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.

PSB. VHA requires that PSB actions and recommendations be submitted to the MEB for review and approval.[8] MEB 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

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

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. While conducting the EOC review, we also inspected areas where EN products were stored, and we interviewed key employees. We determined that the facility generally met EN safety 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.

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

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.

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, 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 15–22, for the full text of the Directors' comments.) We consider Recommendations 1, 7, 9, 10, and 11 closed. We will follow up on the planned actions for the open recommendations until they are completed.

Facility Profile[9]		
Type of Organization	Tertiary care medical center	
Complexity Level	1A	
VISN	16	
Community Based Outpatient Clinics	Conway, AR El Dorado, AR Hot Springs, AR Mena, AR Mountain Home, AR Pine Bluff, AR Russellville, AR Searcy, AR	
Veteran Population in Catchment Area	Approximately 170,000	
Type and Number of Total Operating Beds: • **Hospital, including Psychosocial Residential Rehabilitation Treatment Program**	551	
• **Community Living Center/Nursing Home Care Unit**	152	
• **Other**	None	
Medical School Affiliation(s)	University of Arkansas for Medical Sciences	
• **Number of Residents**	521	
	Current FY (through May 2011)	**Prior FY (2010)**
Resources (in millions):		
• **Total Medical Care Budget**	$529.9	$475.5
• **Medical Care Expenditures**	$338.2	$421.6
Total Medical Care Full-Time Employee Equivalents	1,873	1,852
Workload:		
• **Number of Station Level Unique Patients**	71,880	77,496
• **Inpatient Days of Care:**		
o **Acute Care**	49,873	153,829
o **Community Living Center/Nursing Home Care Unit**	30,907	35,118
Hospital Discharges	6,975	11,032
Total Average Daily Census (including all bed types)	424	422
Cumulative Occupancy Rate (in percent)	76.0	76.6
Outpatient Visits	499,456	738,245

[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**
EOC			
1. Display suicide prevention posters and brochures in highly visible areas throughout the facility.	All areas of both campuses were assessed to determine the most appropriate areas for posters, brochures, and other materials. Staff placed materials in areas highly visible to patients. Posters are located throughout both campuses. Areas are checked routinely for restocking. Compliance is based on appropriate placement of posters	Y	N
2. Ensure EOC performance measures meet VHA standards.	Policy was revised, and staff track all work orders submitted and items that need correction to ensure they do not exceed 14 days. Items not completed within 10 days get referred and must be completed within the next 3 days. A tracking tool was developed, and Engineering reviews it at least weekly.	Y	N
3. Require local policy to clearly designate responsibility for monitoring and maintaining the WanderGuard® system, and ensure compliance.	Policy was revised, and staff developed a tracking mechanism to document WanderGuard® testing. Bracelets are tested at least monthly when not in use and daily when in use. Unit exit door alarms are tested daily. Bracelets are tested prior to placement, and testing is documented.	Y	N

Recommendations	Current Status of Corrective Actions Taken	In Compliance Y/N	Repeat Recommendation? Y/N
Pharmacy Operations and Controlled Substances Inspections			
4. Incorporate all responsibilities of the Controlled Substance Coordinator into local policy.	Policy was updated on 12/19/08 to include all responsibilities.	Y	N
5. Ensure the vault in the North Little Rock outpatient pharmacy is in compliance with VA standards and guidelines.	The correct vault door was installed, inspected, and verified to be within VA standards and guidelines.	Y	N
QM			
6. Ensure provider PI data are collected, analyzed, reviewed, considered as part of the reprivileging process, and recorded in PSB minutes.	The Chief of Staff determined the minimum PI data to be collected for reprivileging. Each service developed a list of PI items to be used for reprivileging. A database was developed for all services to use. PSB minutes now include the PI data used during reprivileging. This information is documented in the minutes.	Y	N
7. Ensure designated staff maintain current Basic Life Support and/or Advanced Cardiac Life Support certifications, in accordance with local policy.	All staff requiring Basic Life Support and/or Advanced Cardiac Life Support were identified and entered on a spreadsheet that is updated when training is completed. This data is sent to services with staff due to expire within 60–120 days. Policy was revised to require staff with lapsed training to be removed from patient care until training is completed.	Y	N

Recommendations	Current Status of Corrective Actions Taken	In Compliance Y/N	Repeat Recommendation? Y/N
Medication Management			
8. Require that local policy defines a specific timeframe for assessing as needed pain medication effectiveness and that responses are documented in a timely manner.	Policy was revised on 4/13/09 to define specific timeframes for screening patient response to as needed pain medications. The policy also requires that patient responses are documented timely. Monitoring of effectiveness documentation is completed monthly.	Y	N

VHA Satisfaction Surveys

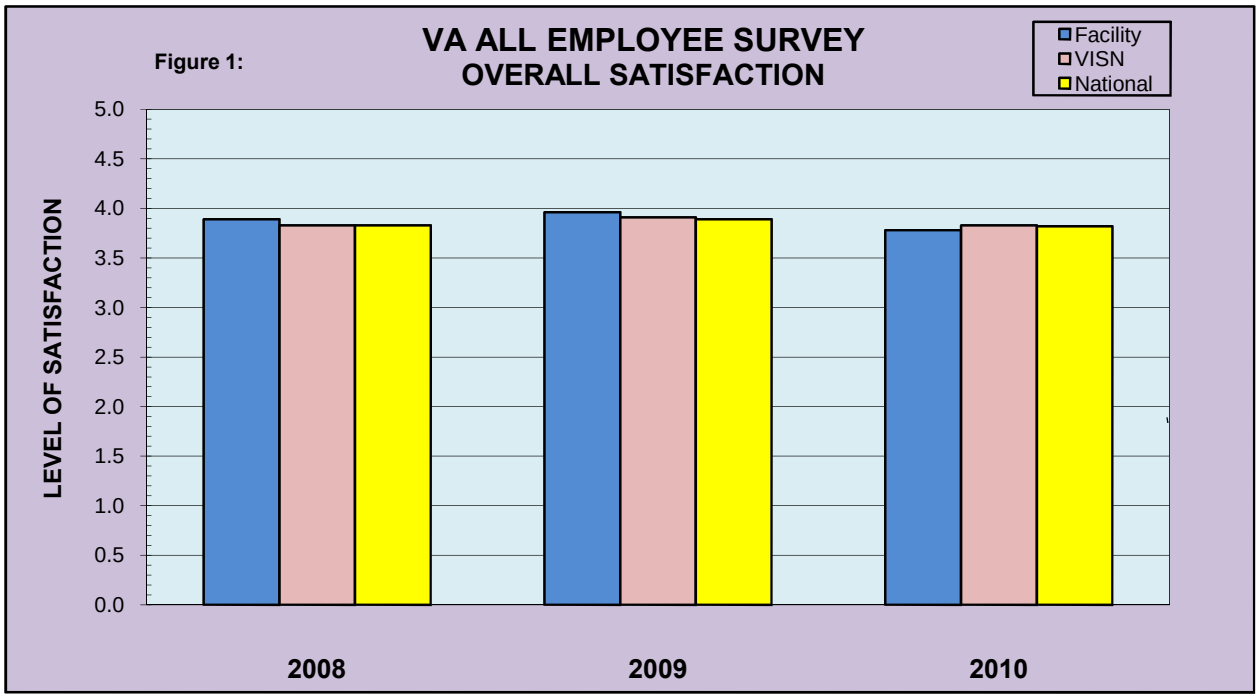
VHA has identified patient and employee satisfaction scores as significant indicators of facility performance. Patients are surveyed monthly. Table 1 below shows facility, VISN, and VHA overall inpatient and outpatient satisfaction scores and targets for FY 2010.

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	67.7	58.0	60.4	57.6	48.7	56.0	52.2	52.6
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[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	13.25	9.96	15.27	21.71	27.32	17.00
VHA	13.31	9.73	15.08	20.57	21.71	15.85

[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: July 15, 2011

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

Subject: **CAP Review of the Central Arkansas Veterans Healthcare System, Little Rock, AR**

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

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

1. I concur with the recommendations presented in the OIG CAP review of the Central Arkansas Veterans Healthcare System.
2. If you have any questions regarding the review, please contact Mary Jones, HSS, at 601-206-6974.

(*original signed by*:)
George H. Gray, Jr.
Director, South Central VA Health Care Network (10N16)

Facility Director Comments

Department of Veterans Affairs **Memorandum**

Date: July 13, 2011

From: Director, Central Arkansas Veterans Healthcare System (598/00)

Subject: **CAP Review of the Central Arkansas Veterans Healthcare System, Little Rock, AR**

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

I concur with the recommendations presented in the OIG CAP review of the central Arkansas Veterans Healthcare System. Actions taken as a result of the recommendations can be found in the following pages.

(*original signed by*:)
MICHAEL R. WINN
Director, Central Arkansas Veterans Healthcare System (598/00)

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 staff adhere to requirements related to labeling chemotherapy infusions and transport.

Concur

Target date for completion: Completed June 29, 2011

All chemotherapy is now prepared within the designated biological safety cabinet (biological safety cabinet, aka "chemo hoods") located on the 6C satellite. Once admixture is complete, the preparer uses isopropyl alcohol to surface clean gloves and medication bag(s)/vial(s). The medication label is affixed while the preparation remains in the biological safety cabinet. The preparation is then placed in the appropriate transport bag and bag is sealed BEFORE preparation is removed from the biological safety cabinet. All staff responsible for preparing chemotherapy is aware of this standard operating procedure.

Request closure of this recommendation as complete.

Recommendation 2. We recommended that the facility medication policy be revised to be consistent with VHA policy and that processes be strengthened to ensure that medication is secured and that access to medication is granted only to those who distribute or administer medication.

Concur

Target date for completion: April 30, 2012

MCM 119-2, Medication Management, will be modified by pen and ink change, para 4. Procedures, c. Storage (2) to exclude access to medications from the list of individuals having access to the medication room. Also, the following statement will be added to the same paragraph: **only those individuals authorized to distribute or administer medications will be allowed access to medications.**

All medications will be secured to allow access only to those individuals who are authorized to administer, distribute or dispense medications. Nursing and Pharmacy will develop appropriate par levels for medications stocked. Renovations (i.e. new cabinets, hasp and lock, band locks, etc.) required to accomplish this measure of security will be completed by Engineering Service by April 30, 2012.

Regarding the North Little Rock Employee Health examination room with medications, on approximately 8-22-11 the North Little Rock Primary Care Clinic on 3E will be moving to 3D. There will be a dedicated area for securing all medications to allow access only to those individuals who are authorized to administer, distribute or dispense medications.

Until the move occurs, Associate Nurse Executive (or designee) will:

1. Insure all staff have been educated on the importance of medication security and appropriate procedures for securing all medications.

2. Perform random weekly monitors to observe that all medications are secured (initiated July 8, 2011).

Recommendation 3. We recommended that processes be strengthened to ensure that annual bloodborne pathogens training and N95 respirator fit testing are completed and that compliance is monitored.

Concur

Target date for completion: September 30, 2011 Blood Borne Pathogen
December 15, 2011 N-95 Fit Testing

Blood Borne Pathogen:

A Talent Management System (VA electronic education system—Talent Management System) module (#1703756) on blood borne pathogen training has been developed by Infection Prevention and Control. A request was sent to Associate Nurse Executive for Education and Education Management Committee to assign this module as mandatory for all staff has been approved. Infection Prevention and Control will also continue to provide face-to-face classes on blood borne pathogens education in New Employee Orientation and periodically as needed until the facility meets its goal. Infection Prevention and Control will monitor facility compliance weekly and report results to facility leadership. Once appropriate compliance level is reached, reports will be monitored monthly and reported to facility leadership. This information will also be reported to the Infection Prevention and Control Subcommittee.

N-95 Fit Testing:

A new SharePoint database (Fit Test) has been developed to document/track N-95 respiratory training and fit testing. The database will be reviewed by the Engineering Safety Officer and Infection Prevention and Control to insure that all appropriate areas are included. All services having employees who need N-95 Fit Testing and Training certification will be identified by August 22, 2011. Training and Fit testing data currently available in Safety Office files will be transferred to the “Fit Test” database by August 30, 2011. The names of current “Fit test" trainers will be shared with their individual service. Additional trainers, if needed, will be accomplished by a request to the Safety Office no later than September 1, 2011. The comprehensive list of staff needing fit testing and training renewals will be compiled and distributed to all

service chiefs, supervisors, and facility leadership no later than September 15, 2011. The electronic database will be monitored weekly by the Safety Officer with weekly reports to facility leadership, with the goal that all required staff is fit tested no later than December 15, 2011. Upon reaching the appropriate compliance goal, the Safety Officer will provide monthly reports of compliance to facility leadership.

Recommendation 4. We recommended that processes be strengthened to ensure that confidential patient information displayed on computer screens is protected from unauthorized access at all times.

Concur

Target date for completion: April 15, 2012

The Privacy Officer has conducted an initial assessment/inventory and identified a total of 15 computers in public access areas on the inpatient nursing units/wards where inappropriate viewing of protected health information might occur. The Privacy Officer will work with services to insure that appropriate privacy screens are placed on these identified computers no later than October 15, 2011. Privacy screens will be mounted in such a manner as to make it difficult, if not impossible to remove them. Environmental Assessment Rounds and informal Privacy Officer Rounds will continue to monitor compliance of safeguarding patient health information.

As individuals standing directly behind employees, at the 15 computers identified, may still be able to view confidential patient health information, even with privacy screens in place, a pilot will be conducted to determine if mirrors could further mitigate the identified privacy risk. Mirror(s) will be installed in the pilot area(s) to assist an employee's knowledge of anyone approaching or standing behind them no later than November 15, 2011. The results of this pilot will be shared with facility leadership no later than December 30, 2011. If this pilot proves to be successful, the remaining identified areas will have mirrors placed no later than January 15, 2012.

A second pilot will be conducted to modify one workstation by inlaying the monitor into the desk/counter top. If successful, all identified workstations will be modified to further mitigate the identified privacy risks for these inpatient ward hallway workstations.

Pilot is to be completed and results reported to facility leadership no later than December 15, 2011. If successful, modifications to other identified workstations to be completed no later than April 15, 2012.

Recommendation 5. We recommended that processes be strengthened to ensure that all components of written advance directive notification are provided to patients and that notification is documented in the medical record.

Concur

Target date for completion: September 30, 2011

Nursing Service monitors Admission Assessments on a daily basis. Advance Directive notification will be included as a critical component in the monitoring process. This information will be made available to Social Work Service and compiled on a quarterly basis. Target goal is ≥90 percent compliance.

Recommendation 6. We recommended that processes be strengthened to ensure that patient advance directive screening is accurately documented in the medical record and that patients receive additional information when it is requested.

Concur

Target date for completion: September 30, 2011

Nursing Service monitors Admission Assessments on a daily basis. Advance Directive notification will be included as a critical component in the monitoring process. This information will be made available to Social Work Service and compiled on a quarterly basis. Social Work Service will be consulted when a patient requests Advance Directive information and/or desires to complete an Advance Directive. During consult completion, if appropriate, Social Workers complete the Advance Directive with the patient or provide the patient with a packet containing information on completion of an Advance Directive with contact information. All Advance Directive consults will be monitored to insure that the patient received the additional information requested, as evidenced by medical record documentation. Target goal is ≥90 percent compliance.

Recommendation 7. We recommended that processes be strengthened to ensure that advance care planning notes are linked to the Crisis, Warning, Allergies and/or Adverse Reactions, and Directives posting.

Concur

Target date for completion: June 30, 2011

Process partially in place, linking Advance Directive planning notes to the Crisis, Warning, Allergies and/or Adverse Reactions, and Directives posting, at time of the survey. While team on site, change was made to insure that all Advance Directive Discussion notes were linked into the Advance Directive planning notes to the Crisis, Warning, Allergies and/or Adverse Reactions, and Directives posting. Monitoring of 50 charts per month will be completed and reported quarterly. Target goal is ≥90 percent compliance.

Request closure of this recommendation as complete.

Recommendation 8. We recommended that processes be strengthened to ensure that meeting minutes track corrective actions to completion.

Concur

Target date for completion: July 22, 2011

Mandatory training sessions are being conducted and include all recorders for facility level committees, boards, and council. These sessions cover appropriate minutes format (issue, discussion, action, responsibility person, target date), along with processes for tracking items to closure, and use of an audit tool to assist in assurance of closing the loop on corrective actions. To date, 31 of 38 required individuals (84 percent) have received the training. Final training sessions are scheduled for July 19 and 22, 2011 to complete the final 7 required attendees.

Recommendation 9. We recommended that processes be strengthened to ensure that PR extensions are requested in writing from and approved by the facility's Director.

Concur

Target date for completion: July 1, 2011

Of the 631 cases reviewed for FY10, only 2 (0.003 percent) were not completed in ≤120 days. Days elapsed for PRs are being tracked and shared at each PR Committee meeting. Cases beyond 80 days will be closed by the next scheduled PR Committee meeting in order to prevent reaching the 120 day limit prior to a meeting. Any cases reaching ≥120 days prior to the next scheduled PR Committee meeting will have an approved request for extension by the Director. Quarterly monitors for the specific element of PRs extending beyond the 120 day limit, with the written approval of the Medical Center Director, will begin FY11Q4.

Request this recommendation be closed as complete.

Recommendation 10. We recommended that processes be strengthened to ensure that the CPR Sub-Committee meets quarterly to evaluate resuscitation events and analyze data.

Concur

Target date for completion: May 24, 2011

The CPR Subcommittee has a newly assigned chair. The subcommittee met on 5/24/11 and changed their process to scheduling meetings monthly which will insure meetings occur at least quarterly as stated in policy. Each resuscitation occurrence is initially evaluated and analyzed by a QM Coordinator. All outliers are then forwarded to the Resuscitation Event Advisory Group for in-depth review, analysis, and consideration for potential PR. Information from the QM Coordinator and Resuscitation Event Advisory Group is then reviewed/analyzed/trended by the CPR Subcommittee. All resuscitation events not previously evaluated were completed at the 5/24/11 meeting.

Request this recommendation be closed as complete.

Recommendation 11. We recommended that the PSB submit actions and recommendations for privileging and reprivileging to the MEB and that MEB meeting minutes include documentation of reviews and decisions.

Concur

Target date for completion: July 12, 2011

PSB recommendations were voted on at the MEB immediately following the PSB meeting (MEB meets immediately after PSB) so as not to delay any actions taken. PSB actions has been added as a standing agenda item for the MEB meeting beginning with the July 12th meeting, thereby insuring documentation of reviews and voting by the entire MEB prior to forwarding to the Medical Center Director.

Request this recommendation be closed as complete.

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