Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 11-00027-162

Combined Assessment Program Review of the Kansas City VA Medical Center Kansas City, Missouri

May 9, 2011

Washington, DC 20420

Why We Did This Review

Combined Assessment Program (CAP) reviews are part of the Office of Inspector General's (OIG's) efforts to ensure that high quality health care is provided to our Nation's veterans. CAP reviews combine the knowledge and skills of the OIG's Offices of Healthcare Inspections and Investigations to provide collaborative assessments of VA medical facilities on a cyclical basis. The purposes of CAP reviews are to:

- Evaluate how well VA facilities are accomplishing their missions of providing veterans convenient access to high quality medical services.
- Provide crime awareness briefings to increase employee understanding of the potential for program fraud and the requirement to refer suspected criminal activity to the OIG.

In addition to this typical coverage, CAP reviews may examine issues or allegations referred by VA employees, patients, Members of Congress, or others.

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Glossary

AD	advance directive
C&P	credentialing and privileging
CAP	Combined Assessment Program
CBOC	community based outpatient clinic
CLC	community living center
COC	coordination of care
ECMS	Executive Committee of the Medical Staff
EOC	environment of care
facility	Kansas City VA Medical Center
FPPE	Focused Professional Practice Evaluation
FY	fiscal year
IC	infection control
JC	Joint Commission
LMS	Learning Management System
MDRO	multidrug-resistant organisms
MSDS	material safety data sheet
OIG	Office of Inspector General
OPPE	Ongoing Professional Practice Evaluation
OSHA	Occupational Safety and Health Administration
PPE	personal protective equipment
PSB	Professional Standards Board
QM	quality management
SOPs	standard operating procedures
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

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Executive Summary: Combined Assessment Program Review of the Kansas City VA Medical Center Kansas City, MO

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 February 7, 2011.

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

- Medication Management
- Quality Management

The facility's reported accomplishments were the patient safety culture change and the Heels' Angels Campaign.

Recommendations: We made recommendations in the following five activities:

Physician Credentialing and Privileging: Ensure Focused Professional Practice Evaluations include time periods for evaluation and specific criteria. Complete Ongoing Professional Practice Evaluations according to facility policy. Submit actions and recommendations for privileging and reprivileging to the Executive Committee of the Medical Staff, and ensure meeting minutes include documentation of reviews and decisions.

Coordination of Care: Update the facility policy on advance directives, and require designated staff to accurately document advance directive notification and screening. Provide copies of discharge instructions to patients or caregivers, and document the provision in the medical record.

Environment of Care: Maintain current material safety data sheet information, and ensure staff receive training on accessing the information electronically. Ensure annual bloodborne pathogens training and N95 respirator fit testing is completed and documented.

Management of Multidrug-Resistant Organisms: Require staff to follow facility infection control policy for contact precautions. Provide infection prevention strategies education to patients infected or colonized with multidrug-resistant organisms and their families, and document the education.

Management of Test Results: Consistently communicate normal test results to patients within the specified timeframe.

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 seven activities:

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

The review covered facility operations for FY 2010 and FY 2011 through February 11, 2011, and was done in accordance with OIG SOPs for CAP reviews. We also followed up on selected recommendations from our prior CAP review of the facility (*Combined Assessment Program Review of the Kansas City VA Medical Center, Kansas City, Missouri,* Report No. 08-00001-134, May 29, 2008). The

facility had corrected all findings. (See Appendix B for further details.)

During this review, we also presented crime awareness briefings for 146 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

Patient Safety Culture Change

Staff members at the facility have taken actions to improve patient safety after managers identified the need for improved communication at all levels of the organization. The National Center for Patient Safety recognized the facility's success in changing the culture for patient safety.

To facilitate the program's goals, managers strategically placed plasma screens throughout the facility that display information to promote patient and staff safety; initiated a greeter program, mystery shoppers, a shuttle service, and improved signage; and developed a log to allow reporting of patient safety concerns and provide daily feedback to those reporting the concerns.

Heels' Angels Campaign

The purpose of the Heels' Angels Campaign is to decrease hospital-acquired heel pressure ulcers. The project's goals are to improve quality of patient care and to decrease pain and suffering, cost, hospitalizations, infection, amputations, and death. Project activities since 2009 include initiating mandatory staff skin care classes and utilizing heel lift boot decision tree guidelines.

Since the initiation of the campaign, team leaders report a 74 percent decrease in heel pressure ulcers. This has resulted in significant cost savings to the facility.

Results

Review Activities With Recommendations

Physician C&P

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

We reviewed 11 physicians' C&P files and profiles and found that licenses were current and that primary source verification had been obtained. However, we identified the following areas that needed improvement.

FPPE. VHA requires that an FPPE be initiated for all physicians who have been newly hired or granted new privileges.[1] FPPEs must be time-limited and must include specific criteria that define the evaluation process. We reviewed seven applicable providers' FPPEs and found that only one FPPE documented both time periods for evaluation and specific evaluation criteria.

OPPE. Facility policy requires that data consistent with service-specific competency criteria be gathered concurrently and reviewed in 6-month intervals by the service chief. Although we found sufficient competency data to meet current requirements, only 6 of 11 applicable OPPE assessments were completed according to facility policy. Five assessments were not completed in the required timeframe.

PSB. VHA requires that PSB actions and recommendations be submitted to the ECMS.[2] ECMS meeting minutes did not include documentation of the review or approval of PSB privileging or reprivileging recommendations prior to granting privileges for the 11 physicians whose folders we reviewed.

Recommendations

1. We recommended that processes be strengthened to ensure that FPPEs include both time periods for evaluation and specific criteria.

2. We recommended that OPPE assessments be completed according to facility policy.

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

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

COC

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

We reviewed facility policies, and we reviewed patients' medical records for documentation of advance care planning, ADs, and discharge instructions. We identified the following areas that needed improvement.

Documentation of AD Notification and Screening. VHA requires that facility directors identify the staff responsible for conducting AD notification and screening for patients and that AD notification and screening are documented in the medical record at each admission to a VHA facility.[3] Facility policy did not designate the staff responsible for providing AD notification. We reviewed the medical records of 10 patients and found no documentation of AD notification.

Although AD screenings were completed for all patients whose records we reviewed, only 6 of the 10 screenings were accurate. Four screenings documented that there were no ADs; however, we located ADs for those patients in the electronic medical records.

Discharge Instructions. The JC requires that upon discharge from a facility, clinicians provide patients with written discharge instructions. We reviewed the medical records of 10 discharged patients and found that 8 records had documentation that the patient or caregiver received a copy of the discharge instructions.

Recommendations

4. We recommended that facility policy be updated to designate the staff responsible for AD notification and screening and that processes be strengthened to ensure that designated staff accurately document AD notification and screening for patients.

5. We recommended that processes be strengthened to ensure that staff provide copies of discharge instructions to

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

patients or caregivers and document that they provided the instructions in the medical record.

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 inpatient units (medical, surgical, medical and surgical intensive care, and locked behavioral health), the emergency department, radiology, and outpatient clinics. The facility maintained a generally clean and safe environment. However, we identified the following conditions that needed improvement.

MSDS Information. OSHA requires that MSDS information be available in each clinical area. We inspected eight clinical areas and found outdated MSDS hard copies in all areas. In addition, staff in only two of the eight clinical areas were aware of and could access the electronic MSDS system.

IC. OSHA requires that all employees receive initial and annual training on the OSHA Bloodborne Pathogens Rule. We reviewed 20 employee training records and found that 10 employees had this training documented.

If facilities use N95 respirators, OSHA requires that designated employees are fit tested annually. We reviewed 23 employee training records and determined that four designated employees had the required annual fit testing.

Recommendations

6. We recommended that current MSDS information be maintained and that staff receive training on accessing the information electronically.

7. We recommended that annual bloodborne pathogens training and N95 respirator fit testing be completed and documented.

Management of MDRO

The purpose of this review was to evaluate whether the facility had developed a safe and effective program to reduce the incidence of MDRO in its patient population in accordance with applicable requirements.

We reviewed 18 employee MDRO training records and interviewed five employees regarding contact isolation and cleaning procedures. We identified no deficits. In addition,

we inspected medical, surgical, and progressive care units. We identified the following areas that needed improvement.

Contact Precautions. Facility IC policy requires that staff follow contact precautions for patients who are colonized or infected with MDRO. This includes the use of PPE and appropriate hand hygiene. We observed seven facility staff who entered contact isolation rooms and found that four complied with facility policy on hand hygiene and PPE.

Patient/Family Education. The JC requires that patients infected or colonized[4] with MDRO and their families receive education on infection prevention strategies, such as hand washing and the proper use of PPE. We reviewed 10 medical records and found that only 6 records had documentation of MDRO education.

Recommendations

8. We recommended that staff follow facility IC policy for contact precautions.

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

Management of Test Results

The purpose of this review was to follow up on a previous review that identified improvement opportunities related to documentation of notification of abnormal test results and follow-up actions taken.[5]

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

Communication of Normal Results. VHA requires facilities to communicate normal results to patients no later than 14 calendar days from the date that results were available to the ordering provider.[6] We reviewed the medical records of 20 patients who had normal results and found that 15 of the 20 records contained documented evidence that facility staff had communicated results to the patients.

[4] Colonization is the presence of bacteria in the body without causing clinical infection.
[5] *Healthcare Inspection Summary Review –Evaluation of Veterans Health Administration Procedures for Communicating Abnormal Test Results;* Report No. 01-01965-24; November 25, 2002.
[6] VHA Directive 2009-019, *Ordering and Reporting Test Results,* March 24, 2009.

Recommendation **10.** We recommended that staff consistently communicate normal test results to patients within the specified timeframe.

Review Activities Without Recommendations

Medication Management

The purpose of this review was to determine whether the facility employed safe practices in the preparation, transportation, 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 pharmacy and the chemotherapy clinic. We also interviewed staff. We determined that the facility safely prepared, transported, and administered the medications. We made no 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. The QM program was generally compliant with requirements, and senior managers supported the program. 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 full text of the Directors' comments.) We will follow up on the planned actions until they are completed.

Facility Profile[7]		
Type of Organization	Tertiary care medical center	
Complexity Level	1c	
VISN	15	
CBOCs	Belton, MO Cameron, MO Excelsior Springs, MO Nevada, MO Paola, KS Warrensburg, MO	
Veteran Population in Catchment Area	152,718	
Type and Number of Total Operating Beds: • **Hospital, including Psychosocial Residential Rehabilitation Treatment Program**	187	
• **CLC/Nursing Home Care Unit**	N/A	
• **Other**	N/A	
Medical School Affiliation(s)	University of Missouri-Kansas City University of Kansas	
• **Number of Residents**	92.5	
	Current FY (through December 2010)	**Prior FY (2010)**
Resources (in millions):		
• **Total Medical Care Budget**	$271	$294
• **Medical Care Expenditures**	$60	$294
Total Medical Care Full-Time Employee Equivalents	1,473	1,454
Workload:		
• **Number of Station Level Unique Patients**	27,716	44,518
• **Inpatient Days of Care:**		
o **Acute Care**	5,490	33,989
o **CLC/Nursing Home Care Unit**	N/A	N/A
Hospital Discharges	1,126	6,805
Total Average Daily Census (including all bed types)	90	93
Cumulative Occupancy Rate (in percent)	69.8	72.2
Outpatient Visits	79,286	474,523

[7] 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. Complete peer reviews in 120 days.	Since the last OIG visit, annual completion rates in 120 days have improved from 73 percent in FY 2007 to 96 percent in FY 2008, 99.4 percent in FY 2009, and 94 percent after 3 quarters in FY 2010. We established a tighter system of tracking initial reviews.	Y	N
Pharmacy Operations			
2. Secure access for outpatient controlled substances storage cabinet.	The outpatient controlled substance storage cabinet has been fitted with an electronic system.	Y	N
3. Conduct weekly nursing inventories of automated medication dispensing machines.	Nurses perform weekly inventories of the automated medication dispensing machines. Pharmacy conducts a weekly run of the Pyxis to ensure that nurses are conducting inventories.	Y	N
EOC			
4. Secure access to supplies, medications, utilities, and medical records, and limit access to outside contaminants.	These have been corrected and are closely monitored during weekly EOC rounds. Noted deficiencies are recorded and tracked for prompt corrective action.	Y	N
5. Require designated team members to participate on EOC rounds.	A system has been developed to track designated team member participation in EOC rounds.	Y	N

Recommendations	Current Status of Corrective Actions Taken	In Compliance Y/N	Repeat Recommendation? Y/N
6. Conduct semi-annual EOC inspections at CBOCs.	CBOC inspections are conducted every 6 months to ensure the safety of patients, staff, and visitors.	Y	N
7. Ensure that all locked inpatient psychiatric unit staff receive training on environmental hazards that pose a threat to suicidal patients.	All staff on the locked inpatient psychiatric unit completed the required environmental hazards training.	Y	N

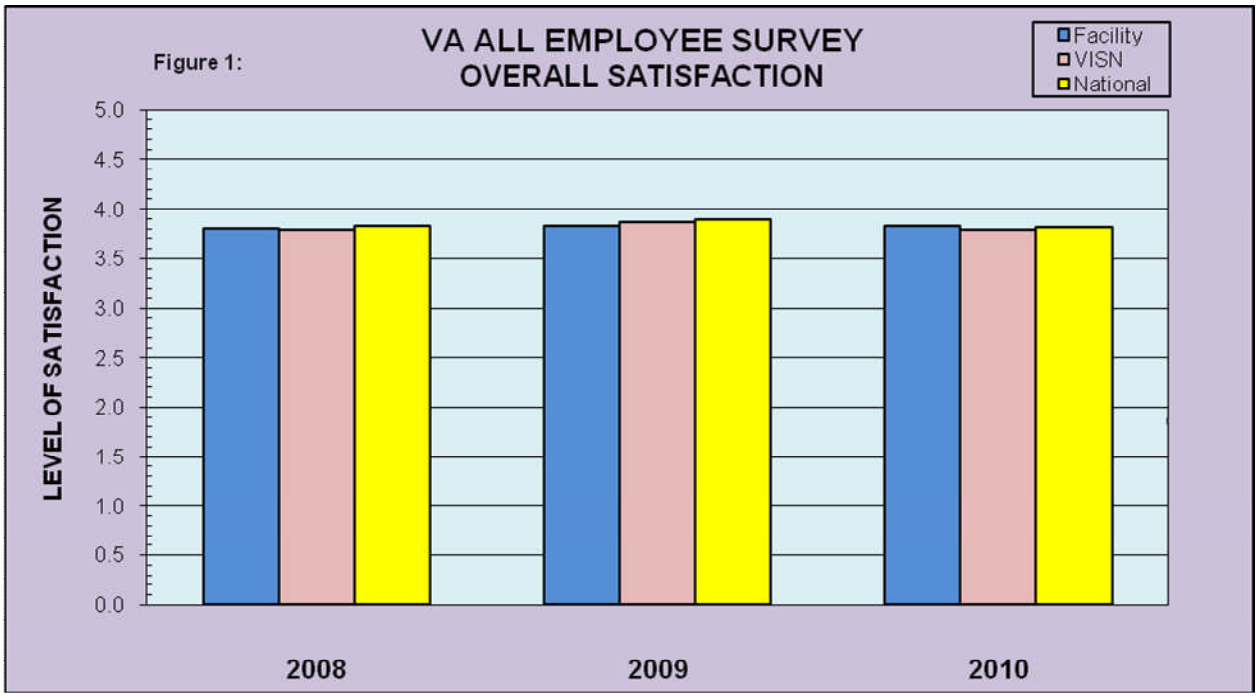
VHA Satisfaction Surveys

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	60.0	58.2	58.8	55.0	59.8	54.1	52.6	58.7
VISN	59.0	56.0	56.9	55.2	53.5	52.9	51.6	52.5
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.



Hospital Outcome of Care Measures

Hospital Outcome of Care Measures show what happened after patients with certain conditions[8] 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	CHF	Pneumonia	Heart Attack	CHF	Pneumonia
Facility	13.33	9.73	13.49	20.5	22.25	17.23
VHA	13.31	9.73	15.08	20.57	21.71	15.85

[8] Congestive heart failure (CHF) 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: April 14, 2011

From: Director, VA Heartland Network (10N15)

Subject: **CAP Review of the Kansas City VA Medical Center Kansas City, MO**

To: Director, Kansas City Office of Healthcare Inspections (54KC)

Director, Management Review Service (VHA CO 10B5 Staff)

I have reviewed the recommendations and concur with the responses and action plans. If you have any questions, please contact our office at 816.701.3000.

(original signed by:)
JAMES R. FLOYD, FACHE
Director, VA Heartland Network (10N15)

Facility Director Comments

Department of Veterans Affairs **Memorandum**

Date: April 14, 2011

From: Director, Kansas City VA Medical Center (589/00)

Subject: **CAP Review of the Kansas City VA Medical Center, Kansas City, MO**

To: Director, VISN 15 (10N15)

Attached, please find the responses to the OIG report.

(original signed by:)
KENT HILL
Director, Kansas City VA Medical Center

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 FPPEs include both time periods for evaluation and specific criteria.

Concur

Target date for completion: Recommend this item be closed.

Timeframes and criteria were discussed with appropriate Service Chiefs and with the ECMS. All appropriate Service Chiefs were re-educated. Ongoing monitoring is performed by Performance Improvement staff. When FPPEs are received, they are reviewed by Performance Improvement staff and Chief of Staff and if not fully completed they are returned to the Service Chief.

Extract from facility credentialing & privileging policy memorandum on FPPE process:

Focused Practice Evaluation (FPE): Focused Practice Evaluation is a process whereby the organization evaluates the privilege-specific competence of the practitioner who does not have documented evidence of competently performing the requested privilege at the organization, and specifically with all initially requested privileges. This process also may be used when a question arises regarding a currently privileged practitioner's ability to provide safe, high quality patient care. Focused professional evaluation is a time-limited period during which the organization evaluates and determines the practitioner's professional performance, e.g. 6 months or otherwise designated. Criteria for extending the evaluation could be related to lack of sufficient number of cases performed during timeframe, questions or concerns that require further evaluation or observation. Results and recommendations are provided to the Service Chief who will submit to the ECMS. Changes will be implemented to improve performance if indicated. Triggers that indicate the need for performance monitoring are clearly defined based on single incidents or evidence of a clinical practice trend.

Recommendation 2. We recommended that OPPE assessments be completed according to facility policy.

Concur

Target date for completion: Recommend this item be closed.

There were timeliness issues for service lines who did not complete written documentation of their assessments and refer to ECMS timely. Timeliness issues and expectations have been discussed at ECMS and with Service Chiefs by the Chief of

Staff. OPPEs are to be completed in writing no later than 3 months post evaluation period. Performance Improvement staff perform concurrent monitoring for the next two consecutive OPPE cycles to assure timely submission and will continue this process as required.

Recommendation 3. We recommended that the PSB submit actions and recommendations for privileging and reprivileging to the ECMS and that ECMS meeting minutes include documentation of reviews and decisions.

Concur

Target date for completion: Recommend this item be closed.

PSB agenda items/actions presented at ECMS. This has been done at ECMS meetings subsequent to the OIG visit (March and April 2011) and will be an agenda item each month at ECMS.

Recommendation 4. We recommended that facility policy be updated to designate the staff responsible for AD notification and screening and that processes be strengthened to ensure that designated staff accurately document AD notification and screening for patients.

Concur

Target date for completion: June 1, 2011

Policy revision is currently underway.

Recommendation 5. We recommended that processes be strengthened to ensure that staff provide copies of discharge instructions to patients or caregivers and document that they provided the instructions in the medical record.

Concur

Target date for completion: Recommend this item be closed.

Policy revised; the section requiring a copy of the discharge instructions in the medical record was deleted. Revised policy has been uploaded and staff instructed.

Discharge Instruction Template was amended on March 1, 2011, to include the following statement: “A copy of the discharge instruction given to Patient Family.” Ongoing monitoring will occur.

Recommendation 6. We recommended that current MSDS information be maintained and that staff receive training on accessing the information electronically.

Concur

Target date for completion: June 30, 2011

Current MSDS information to be maintained; thus Safety Officer coordinating with Administrative Officers to ensure accurate MSDS inventory is maintained. Staff will be given training regarding the electronic MSDS inventory.

Recommendation 7. We recommended that annual bloodborne pathogens training and N95 respirator fit testing be completed and documented.

Concur

Target date for completion: June 30, 2011

Annual bloodborne pathogen training: Service Chiefs review and follow up with staff to ensure compliance (annual training completed within a 12-month period). N95 fit testing will be completed and documented.

Recommendation 8. We recommended that staff follow facility IC policy for contact precautions.

Concur

Target date for completion: Recommend this item be closed.

Education:

- Initial Education: Infection Control Practitioners (ICPs)
    - Prepare educational packet:
        - Status: Completed February 9, 2011.
    - Provide initial education to areas starting February 10, 2011 through March 15, 2011.
        - Status: Completed March 15, 2011.
        - ICPs provided education to all units, offering 28 sessions for 262 staff.
    - ICPs will distribute to Managers the sign in sheets for the in-services provided by the ICPs.
        - Status: Completed March 15, 2011.
        - Managers were also provided with the LMS report of staff who attended the training.
        - Managers of each area to provide education to any staff not able to attend the initial training.
    - ICPs will provide a copy of the educational packet to Education so that the title can be entered into LMS.
        - Status: Completed February 28, 2011.
        - Face to face, session was created in LMS for Education to enter attendance, completed March 15, 2011.

Monitoring:

- Acute units will monitor PPE compliance in their units on an ongoing basis and report data to the IC Office by the last business day of the month for the reporting

month. Service Chiefs will ensure that the monthly data reports provided by the IC Office are distributed and discussed at the staff level.

- Responsible: Nurse Co-leaders, Service Chiefs, Area Managers
  Completion: Process well established. Ensure monthly compliance.

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

Concur

Target date for completion: Recommend this item be closed.

Action:

- Re-education: Refresher education presented by Nurse Managers during March 2011 regarding the Patient Education Infection Prevention and Control template in the electronic medical record.
  - Reminder announcement at Executive Committee of Nursing Staff meeting March 16, 2011.
- Monitor: Associate Director of Patient Care Services to ensure compliance with documentation as demonstrated by chart review of five charts per acute care unit per month starting April 2011.
- Sustain: Additional action plans will be based on findings of the April 2011 monitor.

Recommendation 10. We recommended that staff consistently communicate normal test results to patients within the specified timeframe.

Concur

Target date for completion: September 15, 2011

In addition to notifying patients of test results face to face during clinic visit and by phone, we have also disseminated a letter template to Primary Care Providers to facilitate notification of test results. In addition, we are in the process of procuring a printer and software, similar to Tampa VA's program, to facilitate mailing lab results to patients on a routine basis. It is our intent to rollout the process facility-wide.

OIG Contact and Staff Acknowledgments

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