Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 11-00024-152

Combined Assessment Program Review of the Wilmington VA Medical Center Wilmington, Delaware

April 27, 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
CBOC	community based outpatient clinic
CHF	congestive heart failure
CLC	community living center
COC	coordination of care
CWAD	Crises, Warnings, Allergies, and/or Adverse Reactions
ECMS	Executive Committee of the Medical Staff
EOC	environment of care
facility	Wilmington VA Medical Center
FY	fiscal year
ICU	intensive care unit
JC	Joint Commission
MDRO	multidrug-resistant organisms
MEC	Medical Executive Committee
OIG	Office of Inspector General
OSHA	Occupational Safety and Health Administration
PI	performance improvement
QM	quality management
RCA	root cause analysis
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

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Executive Summary: Combined Assessment Program Review of the Wilmington VA Medical Center, Wilmington, DE

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
- Physician Credentialing and Privileging

The facility's reported accomplishments were the receipt of a Silver Cornerstone Award for patient safety and the Hospice Initiative for Homeless and Rural Veterans.

Recommendations: We made recommendations in the following five activities:

Environment of Care: Complete and document N95 respirator fit testing annually. Strengthen processes to ensure medication security.

Quality Management: Implement a plan to address the delivery of care to patients held in temporary bed locations. Strengthen processes to ensure that:

- Quality management-related committees develop specific action plans when problems are identified and track action items to completion.
- Analysis of data related to resuscitation episodes includes all required elements.
- All required components are included in medical record reviews and that results are reported quarterly.

Management of Multidrug-Resistant Organisms: Provide infection prevention strategies education to patients infected or colonized with multidrug-resistant organisms and their families, and document it.

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

Coordination of Care: Provide and document advance directive notification, use required progress note titles to document advance care planning, link note titles to electronic medical record postings, and ensure discharge instructions include appropriate diet orders.

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 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 Wilmington VA Medical Center, Wilmington, Delaware,* Report No. 08-01428-11,

October 21, 2008). The facility had corrected all prior findings. (See Appendix B for further details.)

During this review, we also presented crime awareness briefings for 201 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

Silver Cornerstone Award

The facility received a Silver Cornerstone Award in 2010 from the National Center for Patient Safety for the timeliness of and strength of action plans for RCAs.[1]

Hospice Initiative for Homeless and Rural Veterans

The Hospice Initiative for Homeless and Rural Veterans partnership focuses on outreach to homeless and rural veterans. Partners include the Delaware End of Life Coalition, Delaware Hospice, Delaware Veterans Home, the facility, and state veterans service officers. The program is a national model and provides education about veterans' special needs at the end of life to first responders (police officers, paramedics, and firefighters) and community hospices.

Results

Review Activities With Recommendations

EOC

The purpose of this review was to determine whether the facility maintained a safe and clean health care environment in accordance with applicable requirements.

We inspected the emergency department, a medical/surgical unit, an ICU, a dialysis unit, outpatient clinical areas, the dental clinic, the CLC, and the radiology department. The facility maintained a generally clean and safe environment. However, we identified the following conditions that needed improvement.

[1] An RCA is a tool or method used to determine why a problem happened and what can be done to prevent the problem from happening again.

Infection Control. If facilities use N95[2] respirators, OSHA requires that designated employees are fit tested annually. We reviewed 20 employee training records and determined that 3 designated employees had the required annual fit testing.

Medication Security. JC standards require all medications to be secured from access by unauthorized persons. We found that only four of the seven clinical units inspected had secured medication storage.

Recommendations

1. We recommended that annual N95 respirator fit testing be completed and documented.

2. We recommended that processes be strengthened to ensure that medication security is maintained.

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.

Action Plan Documentation. The JC requires facilities to collect and analyze data on important quality measures and to take action based on that analysis. Meeting minutes from multiple QM-related committees did not document specific action plans when problems were identified. For example, the facility identified a problem with the overhead paging system but did not identify a specific action plan to address the problem.

Resuscitation and Its Outcomes. VHA requires that facilities measure performance of relevant processes in responding to resuscitation episodes.[3] We did not find evidence that the facility analyzed resuscitation data related to errors or deficiencies in technique, malfunctioning equipment, and delays in initiating cardiopulmonary resuscitation.

[2] An N95 respirator mask provides respiratory protection through a tight facial seal and 95 percent filter efficiency. Although the "N" means "not resistant to oil," the respirators are fluid resistant.
[3] VHA Directive 2008-063, *Oversight and Monitoring of Cardiopulmonary Resuscitative Events and Facility Cardiopulmonary Resuscitation Committees*, October 17, 2008.

Medical Record Review. VHA requires facilities to conduct medical record reviews that include specific areas of review and to report the results quarterly.[4] While medical record quality reviews had been completed, we found that they did not include all of the required components. For example, the facility did not monitor documentation of an outpatient visit when one existed in the outpatient scheduling program. We also found that results were reported in only 3 of the 4 required quarters.

Systems Redesign/Patient Flow. The JC requires facilities to have a plan to address the delivery of care to patients who might be held in temporary bed locations. We found that the facility did not have the required plan in place.

Recommendations

3. We recommended that processes be strengthened to ensure that QM-related committees develop specific action plans when problems are identified and track action items to completion.

4. We recommended that processes be strengthened to ensure that analysis of data related to resuscitation episodes includes all required elements.

5. We recommended that processes be strengthened to ensure that all required medical record review components are included and that results are reported quarterly.

6. We recommended that the facility implement a plan to address the delivery of care to patients held in temporary bed locations.

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 inspected the general medicine (4E) unit, an ICU, the hospice unit, and the CLC, and we interviewed eight employees. We identified no deficits in either the inspections or staff interviews. However, we identified the following area that needed improvement.

Patient/Family Education. The JC requires that patients infected or colonized[5] with MDRO and their families receive

[4] VHA Handbook 1907.01, *Health Information Management and Health Records*, August 25, 2006.
[5] Colonization is the presence of bacteria in the body without causing clinical infection.

education on infection prevention strategies, such as hand washing and the proper use of personal protective equipment. We reviewed 11 medical records and found that only 3 had documented evidence of MDRO education.

Recommendation

7. 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.[6]

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 the results were available to the ordering provider.[7] We reviewed the medical records of 20 patients who had normal results and found that only 14 records contained documented evidence that the facility had communicated the results to the patients. Of the results not communicated to the patients, five were radiology results, and one was a laboratory result.

Recommendation

8. We recommended that normal test results be consistently communicated to patients within the specified timeframe.

COC

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

We reviewed patients' medical records for evidence of advance care planning, advance directives, and discharge instructions. We identified the following areas that needed improvement.

Advance Directive Notification. VHA requires that patients be given written notification at each admission stating their right to accept or refuse medical treatment, to designate a

[6] *Healthcare Inspection Summary Review – Evaluation of Veterans Health Administration Procedures for Communicating Abnormal Test Results,* Report No. 01-01965-24, November 25, 2002.
[7] VHA Directive 2009-019, *Ordering and Reporting Test Results,* March 24, 2009.

Health Care Agent, and to document their treatment preferences in an advance directive.[8] Our review of medical records found that facility staff documented notification for only 2 of 10 patients.

Advance Care Planning Progress Note Management. VHA requires that staff use specific progress note titles when documenting advance care planning discussions with patients and link these notes to the CWAD posting[9] in the electronic medical record.[10] We found that local policy correctly referenced the three required note titles. However, two of the note titles had not been incorporated into the electronic medical record menu nor were they linked to the CWAD posting. Therefore, we found that only two of five records reviewed for advance care planning documentation used the required progress note titles and were linked to the CWAD postings.

Discharge Instructions. VHA requires that upon discharge from the facility, providers include information regarding medications, diet, activity level, and follow-up appointments in instructions to patients.[11] In addition, The JC requires that clinicians provide patients with written discharge instructions.

We reviewed the medical records of 10 discharged patients and found that diet instructions did not match diet orders at time of discharge in three of the records. For example, one patient was on a dysphagia[12] diet with thickened liquids at the time of discharge; however, his discharge instructions stated that there were no restrictions on his diet.

Recommendations

9. We recommended that processes be strengthened to ensure that advance directive notification for inpatients is provided and documented.

10. We recommended that the required progress note titles be used to document patient advance care planning and that the notes be linked to the CWAD posting in the electronic medical record.

[8] VHA Handbook 1004.02, *Advance Care Planning and Management of Advance Directives*, July 2, 2009.
[9] CWAD postings allow electronic medical record users to quickly access a status report of important items.
[10] VHA Handbook 1004.02.
[11] VHA Handbook 1907.01.
[12] Dysphagia is a medical term for swallowing difficulty.

11. We recommended that processes be strengthened to ensure that discharge instructions include appropriate diet orders.

Review Activities Without Recommendations

Medication Management

The purpose of this review was to determine whether the facility employed safe practices in the preparation, transport, and administration of hazardous medications, specifically chemotherapy, in accordance with applicable requirements.

We observed the compounding and transportation of chemotherapy medications and the administration of those medications in the oncology clinic, and we interviewed employees. We determined that the facility safely prepared, transported, and administered the medications. We made no recommendations.

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

Comments

The VISN and 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 will follow up on the planned actions until they are completed.

Facility Profile[13]		
Type of Organization	Tertiary care medical center (intermediate)	
Complexity Level	2	
VISN	4	
CBOCs	Dover, DE Georgetown, DE Cape May, NJ Ventnor, NJ Vineland, NJ	
Veteran Population in Catchment Area	115,290	
Type and Number of Total Operating Beds: • **Hospital, including Psychosocial Residential Rehabilitation Treatment Program**	60	
• **CLC/Nursing Home Care Unit**	60	
• **Other**	–	
Medical School Affiliation(s)	Thomas Jefferson University University of Medicine and Dentistry of New Jersey Temple University	
• **Number of Residents**	66	
	Current FY (through October 2010)	**Prior FY (2010)**
Resources (in millions):		
• **Total Medical Care Budget**	$167.2	$175.8
• **Medical Care Expenditures**	$36.3	$173.9
Total Medical Care Full-Time Employee Equivalents	891.6	886.6
Workload:		
• **Number of Station Level Unique Patients**	10,182	25,870
• **Inpatient Days of Care:**		
o **Acute Care**	1,649	9,932
o **CLC/Nursing Home Care Unit**	3,094	19,281
Hospital Discharges	286	1,517
Total Average Daily Census (including all bed types) (in percent)	25.8	25.9
Cumulative Occupancy Rate (in percent)	42.9	66.7
Outpatient Visits	19,538	218,218

[13] 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. Consistently include QM/PI data in provider profiles for consideration at reprivileging.	Ongoing professional practice evaluation plans were developed that include QM/PI data and are considered at reprivileging.	Y	N
2. Ensure completion of required RCAs**.**	Required RCAs were completed and were verified in the annual Risk Management Report in the November 2010 MEC minutes.	Y	N
3. Ensure that moderate sedation and the use of reversal agents are monitored and reported to the appropriate committee.	Surgical Care Review Committee minutes verify that reversal agents are monitored and reported to the appropriate committee. For FY 2010, no reversal agents were utilized.	Y	N
4. Ensure that providers are privileged to perform procedures that are within the capability of the setting for which the privileges were requested and that all privilege actions are documented in the appropriate ECMS minutes.	C&P folders now include setting-specific privileges, and actions are documented in the appropriate ECMS minutes.	Y	N
EOC			
5. Ensure that all designated EOC team members participate in all EOC rounds and that all CBOCs are inspected semi-annually.	EOC rounds and attendance documentation now reflect participation of designated team members in EOC rounds. Also, the EOC team inspects CBOCs semi-annually.	Y	N

Recommendations	Current Status of Corrective Actions Taken	In Compliance Y/N	Repeat Recommendation? Y/N
6. Ensure the reassessment of the number of individuals needed to participate in annual respirator fit testing to support current infectious disease programs.	Following the 2008 CAP, meetings were held to reassess and define the staff to be fit tested. The number was increased during 2009–2010 in response to H1N1 pandemic concerns, and those staff remain on a designated list.	Y	N
COC			
7. Ensure that inter- and intra-facility medical record transfer documentation is complete.	Inter- and intra-facility medical record transfer documentation is now being completed.	Y	N

VHA Satisfaction Surveys

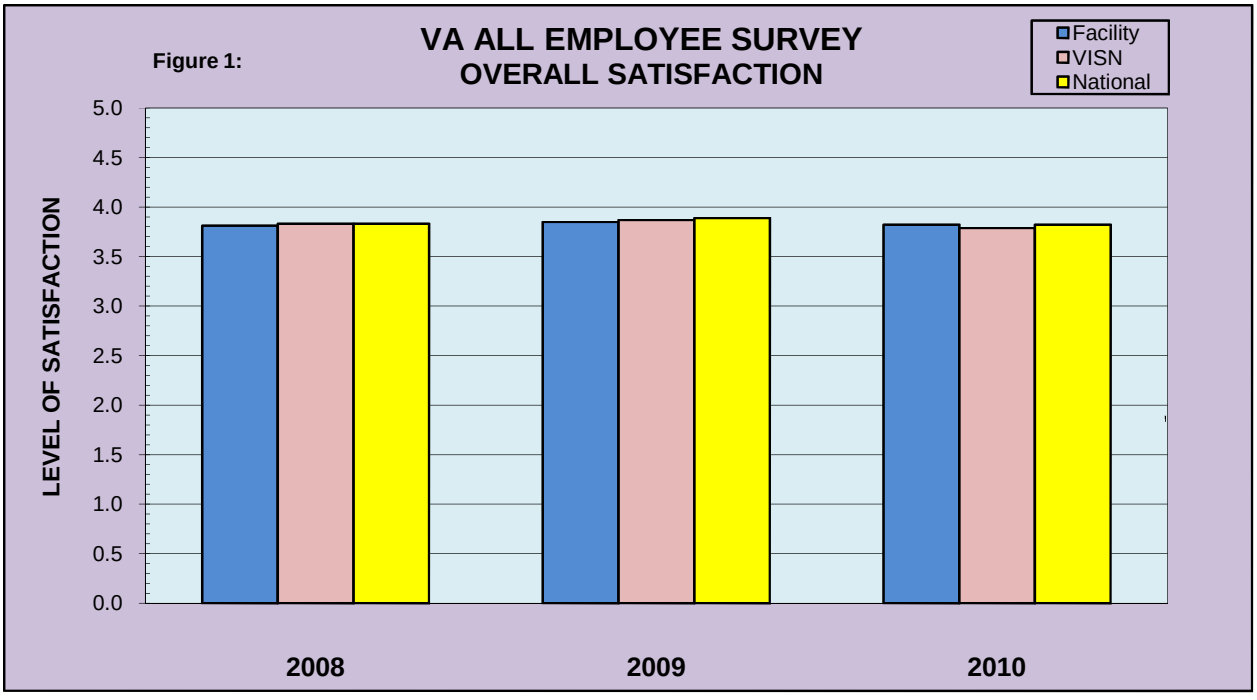
VHA has identified patient and employee satisfaction scores as significant indicators of facility performance. Patients are surveyed monthly. Table 1 below shows facility, VISN, and VHA overall inpatient and outpatient satisfaction scores and targets for FY 2010.

Table 1

	FY 2010 (inpatient target = 64, outpatient target = 56)							
	Inpatient Score Quarter 1	Inpatient Score Quarter 2	Inpatient Score Quarter 3	Inpatient Score Quarter 4	Outpatient Score Quarter 1	Outpatient Score Quarter 2	Outpatient Score Quarter 3	Outpatient Score Quarter 4
Facility	63.2	66.8	66.9	76.0	66.0	50.2	55.8	56.5
VISN	62.7	65.5	65.3	63.0	59.5	61.4	60.1	61.8
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[14] 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	13.8	9.34	13.33	*	22.05	16.99
VHA	13.31	9.73	15.08	20.57	21.71	15.85

* Not enough cases

[14] 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. 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. 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 15, 2011

From: Director, VISN 4 (10N4)

Subject: **CAP Review of the Wilmington VA Medical Center, Wilmington, DE**

To: Director, Baltimore Office of Healthcare Inspections (54BA)

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

1. I have reviewed the responses provided by the Wilmington VA Medical Center in Wilmington, DE and I am submitting it to your office as requested.

2. If you have any questions or require additional information, please contact Barbara Forsha, VISN 4 Quality Management Officer at 412-822-3290.

(original signed by:)
MICHAEL E. MORELAND, FACHE

Facility Director Comments

Department of Veterans Affairs **Memorandum**

Date: April 8, 2011

From: Director, Wilmington VA Medical Center (460/00)

Subject: **CAP Review of the Wilmington VA Medical Center, Wilmington, DE**

To: Director, VISN 4 (10N4)

1. I have reviewed the draft report of the Inspector General's Combined Assessment program (CAP) of the Wilmington VA Medical Center. We concur with the findings and recommendations.

2. I appreciate the opportunity for this review as a continuing process to improve care to our Veterans.

(original signed by:)
CHARLES M DORMAN, FACHE

Director

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 annual N95 respirator fit testing be completed and documented.

Concur

Target date for completion: June 1, 2011

The Safety Manager is responsible to ensure fit testing of designated front line medical staff (ED, ICU, inpatient wards, and CLC). Fit testing occurs during daily operations and off shifts to accommodate staff. Tracking and documentation of fit testing is accomplished using an internal spreadsheet. Results are reported monthly by the Safety Manager to the Safety Committee. Our current compliance rate is 89%.

Recommendation 2. We recommended that processes be strengthened to ensure that medication security is maintained.

Concur

Target date for completion: July 1, 2011

Pharmacy is inspecting all inpatient areas weekly for medication security. Nursing is developing a medication security inspection form to include all inpatient areas, on a rotating day and shift schedule. Results of inspections will be reported to Pharmacy and Therapeutic Committee for tracking and analysis of opportunities for improvement.

Recommendation 3. We recommended that processes be strengthened to ensure that QM-related committees develop specific action plans when problems are identified and track action items to completion.

Concur

Target date for completion: July 1, 2011

The Performance Improvement Board will reeducate all boards, councils, and committees chairpersons and recording secretaries on the Medical Center Memorandum 460-00.20, WILMINGTON VA MEDICAL CENTER MEETING PRINCIPLES AND STRUCTURE that includes a standardized template that has a mandatory action item completion section. The Performance Improvement Board will assess and monitor that QM related committee minutes include discussion and documentation of opportunities for improvement and track items to completion.

Recommendation 4. We recommended that processes be strengthened to ensure that analysis of data related to resuscitation episodes includes all required elements.

Concur

Target date for completion: July 1, 2011

The Medical Center Memorandum 460-111.11 EMERGENCY MEDICAL CARE RESPONSE is under revision. The organization has added technique, equipment and delay in CPR, to the CPR tracking spreadsheet used to report CPR episodes. Results of all CPR episodes are reported to the Healthcare Delivery Council, which meets quarterly for analysis and opportunities for improvement.

Recommendation 5. We recommended that processes be strengthened to ensure that all required medical record review components are included and that results are reported quarterly.

Concur

Target date for completion: July 1, 2011

The Medical Center Memorandum 460-136.53 HEALTH INFORMATION MANAGEMENT DOCUMENTATION POLICY AND PROCEDURES dated February 26, 2011 is complete and includes all required medical record review components in accordance with VHA Handbook 1907.01. The Medical Record Committee scorecard is being adjusted to include all required monitoring components with quarterly reports Medical Executive Board

Recommendation 6. We recommended that the facility implement a plan to address the delivery of care to patients held in temporary bed locations.

Concur

Target date for completion: April 30, 2011

A new Medical Center Memorandum 460-11.57 TEMPORARY BED LOCATION POLICY dated April 8, 2011, is complete. This new Medical Center Memorandum has been distributed to all facility service chiefs; education will occur at the service level. The Memorandum includes details on a monitoring process. Case Management, Utilization Management, and Risk Management will collaboratively review cases when the Full Capacity Plan is implemented and report results to the Performance Improvement Board. Review will evaluate patient flow throughout the organization and include at a minimum all required elements of monitoring in accordance with the VHA Directive.

Recommendation 7. 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: July 1.2011

Our Education Resource Center has developed a new nursing template to be used for MDRO education of patients and family. Nursing staff are currently being in serviced on the new patient education templates. Approximately 50% of the inpatient nursing staff has documented training complete. Training included use of an MDRO template, infection prevention handouts, steps on how to complete medical record documentation, and a survey to assess understanding and use of the education materials. Initially our Quality Management department is monitoring the process, results are being reported to nursing leadership. Plan is for the monitoring process to be taken over by the Nurse Practice Council.

Recommendation 8. We recommended that normal test results be consistently communicated to patients within the specified timeframe.

Concur

Target date for completion: July 1, 2011

Facility is converting the Standard Operating Procedure on Normal Test Results, to a Medical Center Memorandum to strengthen accountability and enhance communication of the required reporting process to meet VHA Directive 2009-019. The new Memorandum will enhance performance monitoring. Results will be tracked by the Medical Record Council. Additionally, instances of non compliance will be reported to Service Chiefs. The Memorandum is being routed through the facility Memorandum process for review and concurrence.

Recommendation 9. We recommended that processes be strengthened to ensure that advance directive notification for inpatients is provided and documented.

Concur

Target date for completion: July 1, 2011

Facility is revising the Medical Center Memorandum 460-11.18 ADVANCED HEALTHCARE PLANNING to include specific designation of who will perform, and document the Advanced Directive notification at the primary care visit and the initial inpatient assessment.

Recommendation 10. We recommended that the required progress note titles be used to document patient advance care planning and that the notes be linked to the CWAD posting in the electronic medical record.

Concur

Target date for completion: July 1, 2011

This recommendation was implemented during the OIG visit. The Advanced Directive note was compliant. Rescinded Advanced Directive note was also linked to the CWAD posting area. The Advanced Directive Discussion note title was created, and linked to CWAD. Communication of changes will occur during our normal Center memo process, which includes review and concurrence by affected services.

Recommendation 11. We recommended that processes be strengthened to ensure that discharge instructions include appropriate diet orders.

Concur

Target date for completion: July 1, 2011

Our Facility is exploring a way to automatically import diet orders into the discharge instruction form, where they could be confirmed or reconciled with any changes that occurred during the admission.

OIG Contact and Staff Acknowledgments

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